

**JABRA ENHANCE's AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
OR PERSONALLY IDENTIFIABLE INFORMATION**

<hr/> Full Name	<hr/> Medical Record / NOAH / Web ID (if known)
<hr/> Address	<hr/> Date of Birth
<hr/> City, State, Zip Code	<hr/> Telephone Number

I hereby authorize the use or disclosure of protected health information or personally identifiable information as described below.

1. The following specific person, class of persons, or facility is/are authorized to receive the protected health information or personally identifiable information described below:

His/Her/Their/Facility Name

Address

City, State, Zip Code

2. The following may use or disclose the protected health information described below:

GN Consumer Hearing Corporation (d/b/a Jabra Enhance)
8001 E. Bloomington Freeway
Bloomington, MN 55420

3. The specific protected health information that may be disclosed involved is as follows (**Please mark appropriate box(es)**):

- Complete medical record
- Partial Medical record (Please clearly specify): _____
- Personally Identifiable Information (Please clearly specify): _____
- Billing Records
- Other (Please clearly specify): _____

For ☞ the following dates of service: _____ or ☞ all available dates of service.

Unless you specifically state otherwise, this authorization **includes** the use, release and disclosure of **all protected health information** including, but not limited to, any and all information pertaining to: (a) drug, alcohol, or substance abuse; (b) psychological, psychiatric, or other mental impairments or developmental disabilities (excluding psychotherapy notes as defined under HIPAA at 45 C.F.R. 164.501); (c) communicable diseases, HIV/AIDS, sexually transmitted diseases, or tuberculosis or the testing of the same; and (d) genetic diseases or tests.

4. Timeframe (please specify date range): ____/____/____20____ to ____/____/____20____

5. The purpose is (**Please mark appropriate box(es)**):

- My medical treatment and related services and products
- Insurance
- Legal _____
- Personal use
- Marketing [_____ receives financial or in-kind compensation, directly or indirectly, in exchange for using or disclosing the Protected Health Information described above.]
- Other, please specify: _____

6. This authorization will remain in effect until (check one):

- The day I withdraw my permission or the date of my death.
- A specific date (mm/dd/yyyy): _____
- A specific event. Please specify: _____

7. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy laws and regulations or state privacy laws and regulations. I hereby release Jabra Enhance and its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or

re-disclosure of the authorized information above.

8. I may revoke this authorization by notifying support@jabraenhance.com in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
9. I understand that Jabra Enhance will not condition treatment, payment, enrollment or eligibility for benefits upon my signing of this authorization.
10. I understand that refusing to sign this form does not stop use or disclosure of my protected health information that is otherwise permitted by law without my specific authorization or permission.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING. By signing below, I acknowledge that I read this form in its entirety and I am legally authorized to consent to the use and disclosure of the protected health information as provided herein.

Signature of Patient or Legally Authorized Representative (The person about whom the information relates)	Date (mm/dd/yyyy)
---	--------------------------

Print Name of Legal Representative (if applicable)	Date of Personal Representative's Signature Description of Authority to Act for the Individual
--	---

A copy of this completed, signed, and dated form must be given to the Individual (or Guardian or Personal Representative). A copy of this authorization is as valid as the original.

Official Use Only
