Idaho Sound Beginnings
Early Hearing Detection and Intervention (EHDI)

PHONE 208-334-0829
FAX 208-332-7330
www.IdahoSoundBeginnings.dhw.idaho.gov

Authorization for Disclosure

I hereby give permission to the _____ (Hospital/Screening site) Staff to release medical information necessary to complete an audiology evaluation for my child to the audiologist/physician of my choice. I also give permission to the Staff and Idaho Sound Beginnings to share the results of the hearing screening, diagnostic audiology evaluations, and early intervention choices (if any) with the above–named physician, the Idaho Infant-Toddler Program, Idaho Educational Services for the Deaf and Blind, Idaho Hands & Voices, and other states' EHDI Coordinators, and care coordination, if needed. I understand that the information will only be used to ensure that appropriate and timely medical, educational, and audiologic services are made available to my child.

No health care provider may condition treatment based on whether you sign this form. Hearing screening results are reported to Idaho Sound Beginnings –Idaho's Early Hearing Detection & Intervention Program and will not be shared with the above listed entities or any other outside entities without parent/guardian consent. Any information disclosed per this authorization may be re-disclosed by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA). You may revoke this Authorization at any time, except to the extent that above-named entities have already acted based on this Authorization. To revoke this Authorization, you must write to:

Idaho Sound Beginnings
IdahoSoundBeginnings@dhw.idaho.gov
450 W. State St.
Boise, ID 83702

I have had the opportunity to read this clinic's Notice of Privacy Practices. This authorization expires 60 months from the date signed.

PATIENT NAME: _____ DATE OF BIRTH:_____

PARENT/GUARDIAN NAME: _____

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____