

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

IMPORTANT: READ ALL INFORMATION ON THIS FORM BEFORE SIGNING.

There may be a charge for copies of medical records unless copies are being sent to another physician or healthcare facility.

PATIENTS NAME _____ BIRTHDATE _____

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
<input type="checkbox"/> Hearing Health Services <input type="checkbox"/> _____ Organization /Person Name	<input type="checkbox"/> Hearing Health Services <input type="checkbox"/> _____ Organization/Person Name
Street Address _____ City, State, Zip _____	Street Address _____ City, State, Zip _____
Phone _____ Fax _____	Phone _____ Fax _____

This request and authorization applies to information relating to audiological analysis, treatment, condition(s), follow up, and/or dates of treatment.

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person(s) or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above-named person(s) or organization(s). I reserve the right to revoke or cancel this authorization, in writing, at any time.

Patient Signature _____ Date _____

Parent or Legal Guardian _____ Date _____

Relationship to patient, if other than patient _____

Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.