Hearing Health Services

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_____ D.O.B._____

INFORMATION TO BE RELEASED **BY**:	INFORMATION TO BE RELEASED **TO**:
☐ Hearing Health Services	☐ Hearing Health Services
☐ _____ Organization /Person Name	☐ _____ Organization/Person Name
_____ Street Address City, State, Zip	_____ Street Address City, State, Zip
_____ Phone Fax	_____ Phone Fax

The type and amount of information to be disclosed is as follows: Audiology Records Only. These include 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 agree to and authorize the release of patient health information to the above-named person(s) or organization(s). Unless otherwise revoked, this authorization will expire in twelve months. I reserve the right to revoke or cancel this authorization, in writing, at any time.

Signature of Patient, Parent, or Legal Guardian _____

Date _____ Relationship to patient, if other than patient_____

Federal laws prohibit the recipient from making any 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.