Hearing & Audiology Services

Medical Records Release

Patient Information:
Name of Patient _____Date of Birth _____

Address _____

City, State, Zip _____Phone #_____

Information to be released from:
(Name & Address of practice)

_____

_____

Information to be released to:
(Name & Address of practice)

_____

_____

Information to be faxed to: 919-841-5663

Information to be released: The pertinent information (hearing tests, hearing aid purchase agreements, noah fitting records, medical chart notes)

This authorization shall be in effect until the information has been forwarded/obtained as requested.

Patient information. I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that I have the right to revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

_____ _____
Signature of Patient or Authorized Person Date

Representative _____

_____
Date

Relationship to Patient _____

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