Authorization to Release Medical Information

Client Name: _____

Address: _____ Date of Birth_____

City/State/Zip_____ Phone: _____

Please RELEASE Information FROM:

Name:

Street Address:

City/State/Zip

Phone Number

Fax Number

Please RELEASE Information TO:

Location:

Street Address:

City/State/Zip

Phone Number

Fax Number

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:

☐ **Current audiometric evaluation**

☐ **Other: _____**

Duration: This authorization shall begin immediately and remain in effect for one (1) year unless otherwise specified as follows:

_____

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

X Signature: _____/____/_____:_____
Dated Time

If signed by other than client, indicate relationship: _____