



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize _____ to release from the medical record of:

Full Name _____

(Please print)

Date of Birth _____ OR Hearing Aid Serial # _____

Current Address _____

Phone # _____

The following information (to include office notes): _____

Send to: _____

Address: _____

Phone#: _____ Fax#: _____

I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclosure of the above information to those persons or agencies named above. I hereby release _____

From all legal responsibility or liability that may arise from the release of these medical records. I understand I may revoke this authorization at any time (except retroactively), and if not revoked earlier, this authorization will automatically expire.

Patient Signature: _____ Date: _____