

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(Please complete this form in its entirety)

I, _____ (Date of Birth: ____/____/____),
(Print patient name)

AUTHORIZE _____
(Name of facility)

LOCATED AT:

Address: _____

City: _____ State: _____ Zip code _____

Phone Number: _____ Fax number: _____

TO DISCLOSE A COPY OF THE HEALTH INFORMATION DESCRIBED BELOW REGARDING THE ABOVE PATIENT TO:

Roseburg Audiology Center
2300 Nw Stewart Pkwy, Ste 103
Roseburg, OR 97471
Phone: 541-672-8868
Fax: 541-672-1142

-In order to better locate your records, please indicate the last time you were seen at the requested office(the one you provided an address for):

☐ Present to 2 years ☐ 3-5 years ☐ 6-10 years ☐ Over 10 years

-Purpose of release: ☐ Transfer of Care ☐ Legal ☐ Other: _____

-I consent to the release of: ☐ All past records ☐ All records from _____ to _____

-Are there any types of records that you do not want released? Yes _____ No _____

If yes, please specify which types of records. _____

I HAVE REVIEWED AND I UNDERSTAND THIS AUTHORIZATION. I ALSO UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT. UNLESS REVOKED EARLIER, THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL MY DEATH.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE: _____

(Print guardian name)