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:

HEARING ASSOCIATES OF FLORENCE

Main office:
1901 HWY 101
Florence, OR 97439
Phone: 541-997-7617
Fax: 541-997-3962

Business office:
2300 NW Stewart Pkway, Ste. A
Roseburg, OR 97471
Phone: 541-672-8868

-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.

_____ DATE: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____

(Print guardian name)