CENTER FOR AUDIOLOGY
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the below identified person, do hereby authorize the release of my medical information, as indicated herein, between the following parties:

RECORDS BEING REQUESTED FROM: ***(choose one/fill in)***

☐ Center for Audiology (Dr. LeJeune, Dr. Carr, or Dr. Crockett)

☐ Physician's Name: _____

Address:_____

City, State, Zip: _____

Phone #_____

Fax # _____

WHEN REQUEST IS COMPLETE: ***(choose one/fill in)***

☐ **Mail To**: _____

_____

_____

_____

☐ **Fax To**: ( )_____

☐ **I Will Pick Up On**: _____

I authorize this release of information for the following reason:

_____

(Ex: Consult/Second Opinion, Specialist Care, Personal Records, Selecting New Physician, Relocating Out of Town, Insurance Change)

I direct that all information obtained in association with this release be held in strict confidence by the recipient and further direct that it is not to be further disclosed without my specific written authorization. I understand that this authorization shall remain in effect for sixty (60) days from the date of my signature below unless I specify an earlier date in this space _____. I understand that except to the extent that action has been taken based in my authorization, I may withdraw this authorization at any time by written notification to the parties involved. I am also releasing information specified below containing treatment for drug and/or alcohol abuse, for psychiatric and/or mental conditions, or HIV test results (if applicable) or diagnosis. I am including this type of information to be released in association with this authorization.

_____	_____	_____
Patients Name When Treated	**Current Contact Phone #**	**Patient Date of Birth**

It is my desire that only the following information indicated below be released as a result of this authorization:

PLEASE CHECK ONE OPTION AND FILL IN ACCORDINGLY:

☐ **Specific Record Description**: _____**Specific Date(s)**:_____

☐ **Complete Chart** *(All Reports, Test Results, and Treatment Notes)*

The patient has the right to revoke this authorization and terminate further disclosure of health information. The patient has the right to review the health information used or disclosed under this authorization. The patient has the right to decline this authorization. Treatment will not be declined unless the authorization was for research-related treatment and information disclosure, or the treatment is solely for the purpose of disclosing to another individual or business. Information that is disclosed under this authorization may be further disclosed by the recipient of the health information. Center for Audiology cannot guarantee the further safeguarding of the health information after disclosure.

_____	_____	_____
Date	**Patient or Guardian Signature**	**Employee Witness Signature**

Completed on:_____ by:_____