Aurora audiology

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Authorization to Release Healthcare Information

PATIENT INFORMATION:

Patient's PRINTED Name:		Date of Birth: / /
Mailing Address:		Date of Request: / /
City:	State:	Home Phone: ( )

❒ PLEASE RELEASE MY RECORDS FROM
(Who has your records currently?)

❒ PLEASE RELEASE MY RECORDS TO
Who should receive your records?)

Name/ Entity:
Address:
Phone: ( ) Fax: ( )
Email:

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

❒ My complete medical record
❒ My medical records from ___/___/___ to ___/___/___
❒ Discharge Summary ❒Audiometric tests ❒History
❒ Other records (specify):

Signature of Patient / Authorized Representative Date

OFFICE USE ONLY:

METHOD: ❒In person ❒ID verified ❒Fax ❒Mail ❒Email Staff initials: