Medical Records Release Form

Aurora audiology

I authorize Aurora Audiology to disclose the following information:

DATE(S) OF SERVICE (APPROXIMATE):

❑ Entire Record ❑ Consultations ❑ Audiometric test(s) ❑ Billing statements and records

❑ Billing or Claims Payment ❑ Other (specify):

RECORD FORMAT + DELIVERY:

❑ Mailed paper copy ❑ Email (PDF) copy ❑ Fax ❑ In-person

INFORMATION TO BE: ❑ RELEASED FROM ❑ RELEASED TO:

Facility/Person Name: _____

Fax: _____ (REQUIRED if records are to be sent to another health care facility or oganization)

Phone: _____

Recipient's email: _____

Address: _____ City: _____ State: _____ Zip: _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, to include **alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire **60 days after the date of signature below** (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Patient's Signature: _____ Date: _____

Parent or Legal Guardian or POA: _____ Date: _____