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Authorization to Release Information

Patient Name: _____
Address: _____
Telephone #: _____
Date of Birth:_____
Social Security: _____
Records Requested From: _____
Requested From Phone #: _____ Fax: _____

Information Requested

_____ H&P exam _____ Lab Reports _____ Hospital Records
_____ Progress Notes _____ X-Ray Reports _____ All Records
_____ Audiograms

Purpose of Disclosure:

_____ Changing Physicians _____ Consult/Second opinion _____ Continuing care
_____ School/Insurance _____ Attorney/SSI Request _____ Worker's Comp
_____ Other (Please Specify) _____

I understand this authorization will expire in one year after it is signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that information obtained of disclosed may be subject to re-disclosure by recipient and no longer be protected by federal or state privacy regulations. I understand that I may refuse to sign this authorization. I further understand that a copy of facsimile of this authorization with my signature may be used with the same effectiveness as an original.

Signature of Patient/Parent/Authorized Person: _____
Print Name: _____ Date: _____

Witnessed By: _____