HEARCARE
Audiology Center

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Release of Medical Records

I ______________________________ authorize the release of my audiologic medical

Records from ____,

to Dr. ______________________with HearCare Audiology Center for the purposes of continuation of care.

The specific information to be released consists of:

1. ____

2. ____

3. ____

Patient DOB ______________________

Patient Signature ______________________________ Date ______________

I understand that this authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified. No time frame may exceed one year after the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information.