HearCare
Audiology Center

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Release of Medical Records

I _____ authorize the release of my ENT and Audiology medical records either indefinitely _____ or from _____ to _____

to Dr. _____ with HearCare Audiology Center for the purposes of _____.

The specific information to be released consist of

1. _____
2. _____
3. _____
4. _____

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.