HearAgainAmerica
Experience the Joy of Hearing
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize _____ to release from the medical record of:

Full Name _____
(Please print)
Date of Birth _____ OR Hearing Aid S/N _____

Current Address _____
Phone # _____

The following information (to include office notes): _____
_____
_____

Send to: _____

Address: _____
Phone #: _____ Fax #: _____

I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclosure of the above information to those persons or agencies named above. I hereby release _____ from all legal responsibility or liability that may arise from the release of these medical records. I understand I may revoke this authorization at any time (except retroactively), and if not revoked earlier, this authorization will automatically expire.

Patient Signature _____ Date _____