MEDICAL RECORD RELEASE

Name (Legal Name) _____ Date of Birth _____

Phone _____

RELEASE FROM

Name _____

Address _____

_____

Phone _____

Fax _____

RELEASE TO

Name _____

Address _____

_____

Phone _____

Fax _____

I request and authorize the transfer and release of my medical record to and from the parties listed above.
I understand that this documentation includes all forms of Protected Health Information (PHI).

☐ **Audiogram (Hearing Test) _____**

☐ **Hearing Aid Contract _____**

☐ **Audiologist or Physician Reports _____**

☐ **Other (specify) _____**

I understand that Mile High Hearing will no longer be responsible for the protection of the PHI except in its original format in their records. The recipient of the medical records becomes responsible for the protection of the PHI once the transfer takes place.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present the written revocation to Mile High Hearing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I certify that this request has been made voluntarily. I understand without written revocation, this authorization will automatically **expire 1 year** from date signed below.

_____ _____

Signature of Patient / Legal Guardian / Power of Attorney **Date**