hearing aids
Karen Scott Au.D.
audiology

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

Date of Birth: _____ Patient's Phone # ( ) _____

Address: _____

City/State/Zip Code: _____

☐ I authorize Karen Scott Hearing Aids and Audiology **to release information to**:

☐ I authorize Karen Scott Hearing Aids and Audiology **to obtain information from:**

☐ I authorize Karen Scott Hearing Aids and Audiology **to obtain and release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # Fax #

I understand that:

- My right to healthcare treatment is not based on the condition of this authorization.
- I understand that if I fail to specify an expiration date this authorization will be valid indefinitely. Valid till _____
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form.
- There may be a charge for the requested records.

Signature of Patient or Representative _____ Date _____

Relationship to Patient (if requester is not the patient) _____