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RELEASE OF INFORMATION – Patient Authorization

_____ _____
Patient Name (Print) Date of Birth

_____
Social Security Number

I AUTHORIZE INFO TO BE RELEASED FROM:

_____
NAME

_____
ADDRESS PHONE

_____
CITY STATE ZIP

RELEASE INFO TO:

Hearing Associates, P.C.
250 South Crescent Dr, Ste 100
Mason City, IA 50401

Medical Information Required:

☐ AUDIOGRAMS ☐ OTOLARYNGOLOGY

Purpose of Release:

☐ TRANSFERRING MEDICAL CARE ☐ REFERRAL

☐ OTHER

EXPLANATION IF OTHER: _____

_____

_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**
(PATIENTS OVER 18 MUST SIGN OWN RELEASE)

_____
RELATIONSHIP, IF NOT PATIENT