

Authorization for Release of Medical Records

Your completion of this form means that you are giving permission for the use and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity receiving your information to complete the sections detailing the information to be released and the purpose for the disclosure.

Patient Name		Date of Birth
Address		Phone
City, State, Zip		
The above-listed patient authoriz	es the following healthcare faci	lity to make record disclosure:
Facility Name		Facility Phone
Facility Address		Facility Fax
City, State, Zip		
Type of Information to Disclose: ☐ Complete Health Record(s) ☐ Laboratory Test Report ☐ Imaging/Report ☐ Audiogram(s) ☐ CDX File (Cochlear Implant Rec	☐ Pathology Report☐ Operative Report☐ Clinical Note(s)	The purpose of disclosure is: ☐ Change of Insurance or Physician ☐ Continuation of Care (ex. VA Med Center) ☐ Referral ☐ Personal Use
☐ Other (Please Specify)		
Dates (If Applicable)		
This information will be disclosed	and used by the following indi	vidual or organization:
Release to		_
Address		
City, State, Zip		☐ Please mail records
Phone	Fax	☐ Please fax records
	Jnless otherwise revoked, this a	time, except to the extent that action has been taken authorization will expire on the following date, event or
Signed (Patient or Legal Guardian)		Date
If legal guardian, please state rela	tionship to patient	
	•	vility Act of 1996 (HIPAA) and California law, this practice

Practices without your authorization.

*CDX files can only be sent via email to an audiologist with access to the programming software for your device. Please provide an email above if you are requesting a transfer of this software file.