AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, __________________________hereby voluntarily authorize the disclosure of information from my health record.

Patient Name____ Telephone Number____________________

Address____ Birthdate______________________

Information Requested From: ____

Information Requested: ____

Facility Address: ____ **Telephone:** _________________

Purpose of Release: ______________________________________ **Fax#:** ______________________

The Information is to Be Provided To:

SLA Audiology
480 East Northfield Dr. Suite 600
Brownsburg, IN 46112
Phone: 317-932-0099
Fax: 317-933-1172

_______________________________________ _________________________

Patient's Signature or Patient's Representative Date

_______________________________________ _________________________

Printed Name of Patient's Representative Relationship to Patient

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose