AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(Please complete this form in its entirety)

I, _____, Date of Birth: ____/____/____ **AUTHORIZE**
(Print patient name)

Name of Facility/Doctor: _____
Address/City/Zip: _____
Phone Number: ( ) _____ Fax Number: ( ) _____

TO USE AND DISCLOSE A COPY OF THE HEALTH INFORMATION DESCRIBED BELOW REGARDING ME TO:

Name of Facility Roseburg Audiology Center
Address/City/Zip: 1931 NW Mulholland Dr., Roseburg, OR 97470
Phone Number: (541) 672-8868 Fax Number: (541) 672-1142

Please indicate the last time you were seen at the requested office in order to better locate your records:
❒ Present to 2 years ❒ 3-5 years ❒ 6-10 years ❒ Over 10 years

PURPOSE OF RELEASE: ❒ Medical Care ❒ Transfer of Care ❒ Legal ❒ Other: _____

I CONSENT TO THE RELEASE OF: ❒ All Records (limited to last 2 years) ❒ All Records from _____ to _____

I HAVE REVIEWED AND I UNDERSTAND THIS AUTHORIZATION. I ALSO UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT. UNLESS REVOKED EARLIER, THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL MY DEATH.

_____ Dated _____, 20_____
(Signature of patient or legal guardian)

_____
(Print guardian name)