Release of Information

Louisville Family Audiology

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Phone: (502) 893-3342
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Date:_____

Release of Hearing Healthcare Records

I, _____ (D.O.B._____), authorize the release of my audiology records from:
Patient's Name

Practice name: _____

Practice Address: _____

Practice Phone #: _____ **Practice Fax #:** _____

To be released to:

Practice Name: _____

Practice Address: _____

Practice Phone #: _____ **Practice Fax #:** _____

This form allows you, as the patient, to choose those persons you want to include and allow access to your personal information. This communication can be changed or voided, by you, at any time. This authorization expires one year from the date signed. The authorization may be revoked in writing at my request. I understand charges for duplicating my records may be incurred.

Signature:_____ Date:_____