1556 N Wenatchee Ave Ste D
Wenatchee, WA, 98801
(P) 509-852-7000
(F) 509-852-7002

Authorization for Release of Medical Record Information

Patient Name: _____ Date of Birth: _____
Address:_____
City/State/Zip:_____
Phone Number:_____

Above listed patient authorizes the following healthcare facility to make record disclosure:
Facility Name:_____ Facility Phone:_____
Facility Address:_____
City/State/Zip:_____
Facility Phone Number:_____ Facility Fax:_____

The purpose of disclosure is:
Change of Insurance or Physician: ☐
Continuation of Care: ☐
Referral: ☐
Other:_____

Dates and Type of information to disclose:
Last 3 years of Diagnostic information (Audiograms, Tympanometry, Auditory Processing): ☐
Last 3 years of Hearing Aid documents and information: ☐
Specific Information Requested: ☐

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

This information may be disclosed and used by the following individual or organization:
Release To: _____
Address:_____
City/State/Zip: _____
Phone Number: _____ Fax Number: _____

Please fax records: ☐ Please mail records: ☐

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not

1556 N Wenatchee Ave Ste D
Wenatchee, WA, 98801
(P) 509-852-7000
(F) 509-852-7002

apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 4 years from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature:_____ Date:_____
Printed Name:_____