The Hearing Center of Lake Charles, Inc.
Hear today. Hear tomorrow.

Authorization for the Release of Medical Information

IMPORTANT: READ ALL INFORMATION ON THIS FORM BEFORE SIGNING.

Patient Name ______________________________ Birthdate ______ /______ /________
MM DD YYYY

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
Organization/Person Name	Organization/Person Name
Street Address City, State, Zip	Street Address City, State, Zip
Phone Fax	Phone Fax

This request and authorization applies to information relating to audiological analysis, treatment, condition, follow up, or dates of treatment.

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing at any time.

Patient Signature ______________________________ Date ____________________

Parent or Legal Guardian ______________________________ Date ____________________

Relationship to patient, if other than patient ______________________________

Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.