

RELEASE OF MEDICAL RECORDS AUTHORIZATION



There is a \$35 processing fee for medical records, plus an additional \$35 per x-ray or CT. You may pay by check, debit card, VISA or MasterCard.

Patient Information

Patient Name: _____ D.O.B.: _____

Address: _____ Phone: _____

Information To Be Disclosed

- Complete health record Complete health record, excluding x-rays/CTs

Or the following individual types of information:

- | | |
|--------------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Chart notes | <input type="checkbox"/> Audiology test results |
| <input type="checkbox"/> Radiological report(s) | <input type="checkbox"/> Laboratory test(s) |
| <input type="checkbox"/> Hearing aid settings/verification | <input type="checkbox"/> Cochlear implant maps |
| <input type="checkbox"/> Speech / Language Therapy | <input type="checkbox"/> Auditory Verbal Therapy |
| <input type="checkbox"/> Electrophysiologic tests/results/reports | |
| <input type="checkbox"/> Consultation/other (please specify) _____ | |

Range of Dates of Treatment

All or From (date) _____ to (date) _____

Disclose To/From

NAME _____

ADDRESS _____

PHONE/FAX _____

Office Address:
1900 University Avenue, Suite
101
E. Palo Alto, CA 94303
Telephone (650) 494-1000
Fax (650) 322-8228

Release

I hereby authorize the above disclosure of information. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition, or one year from the date of this agreement if a date, event, or condition is not specified:

Signed: _____ Date: _____

Name: _____ Title Patient / Parent / Legal Guardian

If legal guardian, please state relationship to patient and attach a copy of the conformed court guardianship

Witness: _____ Date: _____

Name: _____ Phone: _____