Authorization for Release of Health Information

IMPORTANT: *This is a legal document; please complete each section to ensure we are able to process your request*

Patient Name: _____ **Previous Name(s):** _____

Address: _____ **Apt #:** _____
(Street)

_____ **Date of Birth:** _____ **Phone:** _____
(City, State, Zip)

Release Information From:	☐ **Audiology Concepts, LLC (All locations)** ☐ **Tinnitus and Hyperacusis Clinic of MN (All locations)** ☐ **Other:** _____ Street: _____ Phone: _____ Fax: _____ City: _____ State: _____ Zip: _____
Release Information To:	☐ **Audiology Concepts, LLC (All locations)** ☐ **Tinnitus and Hyperacusis Clinic of MN (All locations)** ☐ **Other:** _____ Street: _____ Phone: _____ Fax: _____ City: _____ State: _____ Zip: _____
Method of Disclosure:	☐ Mail ☐ Pick up *(will call when ready, must have written permission if to be picked up by someone other than patient)* ☐ Fax ☐ Email *(to secure emails only)* : _____ ☐ File Only – No Records Needed at this time
Health Information to be Released:	**Date(s): Requesting From:** _____ **To:** _____ *(specific date or date range preferred)* *If no specific date(s) are provided, only the most recent document(s) for items that are check marked below will be sent.* **All Medical Records For:** ☐ Clinic Visits ☐ Hospital Visits (inpatient and outpatient) **Or Specifically/Only:** ☐ Clinic Visit Notes ☐ Audiograms (most recent or all dates) ☐ Amplification programming ☐ Surgical Procedures ☐ Medication List ☐ Prenatal Records ☐ Other (Please specify): _____ I understand the records to be released may include information related to evaluation or treatment of behavioral or mental health, alcohol and drug abuse, and HIV/AIDS. I understand this authorization releases records for dates requested above and may include records prepared or collected by the facility prior to the date of signature on this authorization and/or may include records prepared or collected by the facility after the date of the signature on this authorization.
Reason for Release:	☐ Consult/Treatment ☐ Insurance ☐ Out of town move ☐ Workman's Compensation ☐ Disability ☐ Legal ☐ Personal/Patient request ☐ Other: _____
Authorization:	**This authorization expires on the following date, event or condition:** _____. If I do not specify any expiration date, event or condition, this authorization will expire in one year. **A new Authorization will be required for each new episode of care.** **Statement of Authorization:** • I understand authorizing the release of this information is voluntary. I understand I may inspect or be provided a copy of the information to be used or disclosed, as provided in CRF 164.524. • I understand any release 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 disclosures of my health information, I may contact the facility's Privacy Officer. • I understand the facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. • I understand records may include records that we received from other organizations. If these records have been used by this facility and filed in the record this facility maintains about you, these records may be released with your records.
Signature:	I understand this is a legal document and by signing, I agree that I understand and accept the terms on this form: _____ _____ Signature of Patient or Authorized Representative Date of Signature _____ _____ Printed Name of Patient/Authorized Representative Relationship to Patient or Description of Legal Authority ***(documentation of legal authority required, please submit)***

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