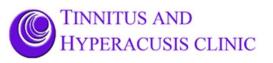


Authorization for Release of Health Information



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:				
(Street)				
(City, State, Zip)				
Release Information	 Audiology Concepts, LLC (All locations) Other: 	ions) 🗆 Tinnitus and Hyperacusis Clinic of MN (All locations)		
From:	Street:	Phone:		_ Fax:
	City:	State:		Zip:
Release Information	 Audiology Concepts, LLC (All locations) Tinnitus and Hyperacusis Clinic of MN (All locations) Other:			
То:	Street: City:	Phone:		_ Fax:
	City:	State:		_ Zip:
Method of	□ Mail □ Pick up (will call when ready, must have written permission if to be picked up by someone other than patient)			
Disclosure:	□ Fax □ Email (to secure emails only) :			
	□ File Only – No Records Needed at this time			
Health	Date(s): Requesting From: To: (specific date or date range preferred)			
Information to be	If no specific date(s) are provided, only the most recent document(s) for items that are check marked below will be sent.			
Released:	All Medical Records For: Clinic Visits Hospital Visits (inpatient and outpatient)			
Releaseu.	Or Specifically/Only: Clinic Visit Notes Audiograms (most recent or all dates) Amplification programming			
	Surgical Procedures Medicat Other (Please specify): I understand the records to be released may include alcohol and drug abuse, and HIV/AIDS. I understand	tion List	to evaluation or	Prenatal Records treatment of behavioral or mental health,
	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	Consult/Treatment Insurance			
Release:	 Disability Legal This authorization expires on the following data 	Personal/Patie	nt request	Other:
Authorization:	 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 			
Signature:	been used by this facility and filed in the record this facility maintains about you, these records may be released with your records. re: I understand this is a legal document and by signing, I agree that I understand and accept the terms on th form:			
	Signature of Patient or Authorized Representa	tive	Date of Signa	ture
	Printed Name of Patient/Authorized Represent	tative		o Patient or Description of Legal Authority n of legal authority required, please submit)