Wake Audiology & Hearing Aid Associates, PLLC
1954 S. Main Street, Wake Forest, NC 27587
Phone: 919-570-8311 / Fax: 919-573-0797

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ D.O.B._____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Work:_____Cell:_____

Records From:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Records To:

Name: Wake Audiology

Address: 1954 South Main Street

City: Wake Forest State: NC Zip: 27587

Phone: 919-570-8311 Fax: 919-573-0797

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization, and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Wake Audiology & Hearing Aid Associates.

Please send the following information:

Audiological Evaluation ____ Hearing Aid Specs ____ Real Ear Measurements ____
Warranty information ____ Chart Notes related to hearing ____

Other _____

Signature of Patient or Guardian: _____ Date: _____