Permission for Verbal & Electronic Communications

Audiology Associates
Alison Metcalf, Au.D.

(Print name of patient) (Date of Birth)

(Street Address) (City, State, Zip Code)

(Phone Number(s)) (E mail)

I permit Audiology Associates and their authorized staff members to discuss my health information in person, by telephone or by electronic mail with any of the following family members or friends involved in my medical care: (List family members or other designated individuals and state the person's relationship to the patient)

Name **Phone Number/E mail** **relationship to Patient**

1._____

2._____

3._____

4._____

Release of information under this document is limited to verbal and electronic discussions with my Health Care Providers. This document does not permit release of any written health information to the individual(s) named above. This authorization will remain in effect for five years unless the patient otherwise notifies this office.

If at any time I do not want verbal or electronic discussions to be permitted between my Health Care Provider and any of the individuals named above, I must notify my Health Care Provider by contacting the medical records department at 503 227 5109.

_____ _____
Patient Signature (Age 14 and over) Date

If a representative (parent/guardian) on behalf of the patient signs this release, complete the following:

Representative's Name:_____

Relationship to Patient:_____

Audiology Associates
1849 NW Kearney St. #200
Portland, OR 97309
Phone 503 227-5109 Fax 503 553-3664