Jacobs Audiology

Authorization to Release Healthcare Information

Patient Name:_____ Date of Birth: _____

Address:_____ City, State, Zip: _____

I request and authorize Jacobs Audiology, LLC to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State:_____ Zip Code:_____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of all records regarding hearing health treatment to the person(s)/clinic listed above

Patient Signature:_____ Date Signed:_____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED.