BAYSIDE AUDIOLOGY & HEARING AIDS

Authorization for Release of Medical Information

Patient Name: ____________________________________ Date of Birth: __________________

Address: ____

City: _________________________ State : __________ Zip: __________

Home Telephone: _________________________ Cell: ______________________________

I hereby authorize Bayside Audiology & Hearing Aids to release a copy of my audiogram and related hearing healthcare records to my:

_____ Physician ____

_____ Insurance Company ____

_____ (Other) ____

OR

Name and Address of Covered Entity authorized to release information:

Name: ____

Address: ____

City: ____________________________ State: _______________ Zip: ____________

Phone: ___________________________ Fax: ________________________________

I hereby authorize said entity to forward **ALL MEDICAL RECORDS (including audiological and hearing aid evaluations)** to:

Bayside Audiology & Hearing Aids
17577 Nassau Commons Blvd.
Suite 103
Lewes, DE 19958
Fax: (302) 645-7604

I understand this authorization is only valid for 60 days from the date of signature if I do not specify a date. I understand that I may revoke this consent at any time, in writing, but not retroactive to the release of information made in good faith. I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA privacy rule. I understand that treatment, payment or other benefits cannot be conditioned on the execution of the Authorization.

Signature ____ Date_________________