



**BAKER AUDIOLOGY  
& HEARING AIDS**

429 W 69<sup>th</sup> St, Sioux Falls, SD 57108  
Phone: 605-306-5756 / Fax: 605-306-5676

**MEDICAL RECORDS REQUEST LETTER**

Date: \_\_\_\_\_

I, \_\_\_\_\_,

hereby authorize \_\_\_\_\_ to

release my medical information to Baker Audiology & Hearing Aids. Please include all my charts, test results, and consultation notes including referrals regarding my medical care.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature/ Guardian Signature

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_