NORTHLAND AUDIOLOGY & Hearing Services

Improve Your Hearing…Improve Your Life!

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RELEASE OF HEALTHCARE INFORMATION TO NORTHLAND AUDIOLOGY

Name of Patient: _____ Date of Birth:_____
(First, Middle Initial, Last) (MM/DD/YYYY)

Provider: _____

Clinic: _____

Phone Number: _____ Fax Number: _____

Information requested:

☐ Audiological test results and report

☐ ENT records related to hearing disorders

☐ Current hearing aid records

Reason for requested information: _____

I authorize Northland Audiology & Hearing Services, Inc. to *receive* the requested healthcare information from the source I have indicated above.

_____ _____ _____
Name Signature Date

Relationship to Patient: ☐ Self ☐ Parent/Guardian ☐ Other: _____

The release of healthcare information will expire two years from dated signature.
The patient has the right to revoke the authorization at any time by submitting a written statement.

FOR OFFICE USE ONLY:

The requested healthcare information was received

via ☐ Fax ☐ Mail ☐ Other: _____ on _____
Date