NORTHLAND AUDIOLOGY & Hearing Services

Improve Your Hearing…Improve Your Life!

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RELEASE OF HEALTHCARE INFORMATION

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

Person Requesting Information: _____

Relationship to Patient: ☐ Self ☐ Parent ☐Guardian
☐ Spouse ☐ Caregiver ☐ Other: _____

Information Requested:_____

_____

_____

Information should be sent to the following individual(s):

1. _____
Name Address and/or Fax Number
2. _____
Name Address and/or Fax Number
3. _____
Name Address and/or Fax Number
4. _____
Name Address and/or Fax Number

Please send this information by: ☐ Fax ☐ Mail ☐ Personal Pickup

_____ _____
Patient or Parent/Guardian Signature Date

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 released to the above named individual(s)

via ☐ Fax ☐ Mail ☐ Personal Pickup by _____ on _____
Name Date