Melody
AUDIOLOGY LLC
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Medical Release Form

Patient Information:
Full Name: _____
Date of Birth: _____
Address: _____
City/State/ZIP: _____
Phone Number: _____
Email Address: _____

Authorization for Release of Medical Information:

I, the undersigned, hereby authorize the release of my medical records related to my audiology care to the following person(s) or organization:

Name of Authorized Person/Organization: _____
Relationship to Patient (if applicable): _____
Phone Number of Authorized Person: _____
Email Address of Authorized Person: _____

Information to be Released:

I authorize the release of the following information (check all that apply):

- ☐ Audiological Evaluation & Recommendations
- ☐ Treatment
- ☐ Other (please specify): _____

Purpose of Release:

- ☐ Continuity of care
- ☐ Personal use
- ☐ Insurance/claims purposes
- ☐ Legal purposes
- ☐ Educational
- ☐ Other (please specify): _____

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Right to Revoke:

I understand that I have the right to revoke this authorization at any time by notifying the audiology clinic in writing. However, such revocation will not affect any actions taken before the revocation.

Conditions:

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

I am aware that I am not required to sign this form, but failure to do so may result in a delay in my care or treatment.

I understand that I have the right to inspect or copy the information to be disclosed, and that I may request a copy of this authorization.

Patient or Legal Representative's Signature:
Signature: _____
Date: _____

If signed by a Legal Representative, please state your relationship to the patient: _____

Expiration of Authorization:

This authorization will expire on: _____ (Date)
If no date is specified, the authorization will remain valid indefinitely.