

Authorization for Release of Information

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____

I hereby authorize Roseville Diagnostic Hearing Center, LLC to **REQUEST** information **From:**

Facility Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

I hereby authorize Roseville Diagnostic Hearing Center, LLC to **RELEASE** my information **TO:**

Facility Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Types of Information to be Disclosed:

<input type="checkbox"/> Entire clinical/medical record	<input type="checkbox"/> Billing Records	<input type="checkbox"/> Other
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Purchase Agreement	
<input type="checkbox"/> Hearing Test Results	<input type="checkbox"/> NOAH fittings	

If you would like any of the following sensitive information disclosed, check below:

<input type="checkbox"/> Alcohol/Drug Abuse Treatment	<input type="checkbox"/> Information about Sexually Transmitted Disease
<input type="checkbox"/> HIV/Aids -related Testing or Treatment	<input type="checkbox"/> Information about mental illness or health
<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> Information about Sexual Abuse or Neglect

TYPES OF DELIVERY METHOD REQUESTED:

<input type="checkbox"/> Paper Copy	<input type="checkbox"/> Electronic Copy/E-mail	<input type="checkbox"/> Fax
<input type="checkbox"/> US Mail	<input type="checkbox"/> Pick Up	<input type="checkbox"/> Other _____

PURPOSE OF RELEASE: Continuing of care Personal Legal Insurance Other _____

This authorization will expire ONE year from the signed date unless revoked or specified below.

Date: _____

By signing this authorization form, I understand that: I may revoke this authorization at any time, in writing, to Roseville Diagnostic Hearing Center, LLC at 1411 Secret Ravine Parkway, Ste. 120 Roseville CA 95661.

I may refuse to sign this authorization and my refusal will not affect my ability to obtain health care services or payment. I have the right to receive a copy of this authorization. I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure.

Signature: _____ **Date:** _____ **Time:** _____

If signed other than patient, print name and relationship: **Name:** _____ **Relationship:** _____

There may be fees incurred for this service.

For Office Use Only: Identification Verified by: _____ Photo ID Matching Signature

Mail or Fax Completed form to: 1411 Secret Ravine Parkway, Suite 120, Roseville CA 95661

FAX Number: (916) 780-4201