Roseville Diagnostic Hearing Center, Inc.

# Authorization for Release of Information

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

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

**Phone**:_____

[ ] **I hereby authorize Roseville Diagnostic Hearing Center, Inc. to <u>REQUEST</u> information <u>FROM</u>:**

**Facility Name**:_____

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

**Phone**: _____ **Fax**: _____

[ ] **I hereby authorize Roseville Diagnostic Hearing Center, Inc. to <u>RELEASE</u> my information <u>TO</u>:**

**Facility Name**:_____

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

**Phone**: _____ **Fax**: _____

**Types of Information to be Disclosed:**

| | | |
|---|---|---|
| [ ] Entire clinical/medical record | [ ] Billing Records | [ ] Other |
| [ ] Progress Notes | [ ] Purchase Agreement | |
| [ ] Hearing Test Results | [ ] NOAH fittings | |

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

| | |
|---|---|
| [ ] Alchohol/Drug Abuse Treatment | [ ] Information about Sexually Transmitted Disease |
| [ ] HIV/Aids -related Testing or Treatment | [ ] Information about mental illness or health |
| [ ] Genetic Testing | [ ] Information about Sexual Abuse or Neglect |

**TYPES OF DELIVERY METHOD REQUESTED:**

| | | |
|---|---|---|
| [ ] Paper Copy | [ ] Electronic Copy/E-mail | [ ] Fax |
| [ ] US Mail | [ ] Pick Up | [ ] 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 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**