



Medical Information Permit to Obtain Medical Records from another Facility.

I hereby grant permission to: \_\_\_\_\_  
(Facility, Provider)  
\_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State) (Zip Code)

To release a copy of my medical records, pursuant to the Privacy Act of 1974 and applicable Federal and State Laws. I understand that the information released upon authority of this authorization may contain information concerning treatment for alcohol, drug abuse, psychiatric condition, or HIV and AIDS related conditions.

This authorization is valid for a period of 60 days from the date of completion of this authorization, and may be revoked by me in writing at any time, except to the extent that action has been taken in reliance thereon.

Specific Information to be released: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For the Purpose of: Patient Care

\_\_\_\_\_  
(Patient Name) / /  
(Date of Birth)  
\_\_\_\_\_  
(Patient Address)  
\_\_\_\_\_  
(Patient Signature) \_\_\_\_\_  
(Date)

If the patient is deceased, administrator of patient's estate or nearest relative may sign. If patient is a minor, parent or legal guardian must sign. Please attach supporting, legal documentation.

\_\_\_\_\_  
(Signature of Authorized Representative) \_\_\_\_\_  
(Date)

North Alabama Audiology Inc.  
Decatur Hearing Aid Center  
920 6<sup>th</sup> Avenue SE  
Decatur, AL 35601  
Fax: 256.355.4772  
Office: 256.353.1016

Faxed on: \_\_\_\_/\_\_\_\_/20

Mailed on: \_\_\_\_/\_\_\_\_/20