MEDICAL INFORMATION PERMIT TO **OBTAIN** MEDICAL RECORDS **FROM** ANOTHER FACILITY.

I hereby grant permission to:

NAME OF FACILITY/PROVIDER_____

STREET:_____

CITY/STATE/ZIP:_____

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, a psychiatric condition, or HIV test results, and AIDS- Related Condition.

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

NORTH ALABAMA AUDIOLOGY, INC
Decatur Hearing Aid Center
920 6th Avenue SE
Decatur, Al 35601
Fax: 256-355-4772 Office: 256-353-1016

PATIENT NAME:_____

PATIENT ADDRESS:_____

DATE OF BIRTH:_____

PATIENT'S 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 below. Please attach supporting, legal documentation.

Signature of Authorized Representative (Please state relationship):

_____DATE:_____/_____/_____

NOTE: An incomplete or improper authorization cannot be honored.

Faxed on _____ or Mailed on:_____
(DATE) (DATE)