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
Huntsville Hearing Aid Center
117-A Longwood Dr. SW
Huntsville, Al 35801
Fax: 256-534-4327 Office: 256-534-2033

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)