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 6th Avenue SE
Decatur, AL 35601
Fax: 256.355.4772
Office: 256.353.1016

Faxed on: _____/_____/20_____ Mailed on: ____/____/20_____