MEDICAL RELEASE FORM

HIPAA Compliant Authorization for the Release of Patient Information Pursuant to 45 CFR 164.508

To _____

Name of Healthcare Provider/Physician/Facility

_____

Street Address / City, State, Zip Code

Re _____ D.O.B. ____/ ____/ _____

Patient Name (Print)

_____

Street Address

_____ Date ____/ ____/ _____

Patient Signature

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ Audiogram ☐ Doctor's Notes ☐ Hearing Aid(s) information (repair/L&D Warranty)

Provider Requesting Patient Records:

Dr. Sandra Hobson, Au.D.
Helping U Hear, LLC

Confidentiality Statement:

This communication is intended only for the use of the individual or entity to whom it is addressed and may contain privileged, confidential information and exempt from disclosure under applicable law. If you have received this communication in error, please notify us immediately and destroy this telecopy transmission.