Denison Hearing
Doctor of Audiology Hearing Healthcare

Patient: _____ DOB:_____ Date: _____

1. Request (check one)
☐ **Send** my records from Denison Hearing **to** the party below
☐ **Obtain** my records **from** the party below, to be sent to Denison Hearing

2. Other party
Practice/organization: _____ Contact: _____
Address: _____ Phone/Fax: _____

3. Information to release (check all that apply)
☐ Complete audiology record ☐ Audiograms/hearing test results ☐ Hearing aid fitting and verification records
☐ Tinnitus records ☐ Visit notes ☐ Billing/insurance records ☐ Other: _____
Dates of service: from _____ to _____ (blank = all dates)

4. Purpose
☐ Continuing care ☐ At my request ☐ Insurance/benefits ☐ Other: _____

5. Expiration
This authorization expires on _____ or upon: _____. If left blank, it expires one year from the date signed.

6. My rights

- I may revoke this authorization at any time by written notice to Denison Hearing at the address above. Revoking it does not affect disclosures already made.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization.
- Information disclosed may be re-disclosed by the recipient and may no longer be protected by federal privacy law.
- I may refuse to sign, and I am entitled to a copy of this authorization.

Signature of patient or representative: _____ Date: _____
If representative, printed name and authority/relationship: _____

Office use: Received by _____ Date _____ ☐ Copy given to patient

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