GREAT LAKES AUDIOLOGY, LLC

3780 King Road
Suite 2C
Toledo, OH 43617
Phone: (419) 327-2273
Fax: (419) 517-4418

Authorization for Release of Medical/Health Records

PATIENT NAME:_____ DATE: _____

DATE OF BIRTH:_____ SOCIAL SECURITY #_____-_____-_____

I authorize Great Lakes Audiology to:

☐ release medical/health records to _____.

☐ obtain medical/health records from _____.

Please send/fax records related to the following to the above address:

- ☐ audiogram
- ☐ tympanometry/otoacoustic emissions
- ☐ electrophysiological testing
- ☐ progress notes/reports
- ☐ hearing instrument documentation
- ☐ cochlear implant/BAHA documentation

I understand that I may revoke this consent at any time and that this consent will automatically expire 90 days from the date signed below. This hereby releases the sender from all legal responsibility or liability which may result from the release of my medical records.

_____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE **DATE**

_____

PRINTED NAME

SPECIAL INSTRUCTIONS/REQUESTS: