

**RELEASE OF MEDICAL RECORDS
AUTHORIZATION**



There is a \$25 processing fee. You may pay by check, debit card, VISA or MasterCard.

Patient Information

Patient Name: _____ D.O.B.: _____
Address: _____ Phone: _____

Information To Be Disclosed

Complete health record(s)

Or the following individual types of information:

- Chart notes
- Radiological report(s)
- Hearing aid settings/verification
- Speech / Language Therapy
- Electrophysiologic tests/results/reports
- Consultation/other (please specify) _____
- Audiology test results
- Laboratory test(s)
- Cochlear implant maps
- Auditory Verbal Therapy

Range of Dates of Treatment

All or From (date) _____ to (date) _____

Disclose To/From

NAME _____
ADDRESS _____
PHONE/FAX _____

PALO ALTO
 1900 University Avenue, Suite 101
 E. Palo Alto, CA 94303
 Telephone (650) 494-1000
 Fax (650) 322-8228

SAN RAMON
 5801 Norris Canyon Road, Suite 200
 San Ramon, CA 94583
 Telephone (925) 830-9116
 Fax (925) 866-1699

Release

I hereby authorize the above disclosure of information. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition, or one year from the date of this agreement if a date, event, or condition is not specified:

Signed: _____ Date: _____

Name: _____ Title Patient / Parent / Legal Guardian

If legal guardian, please state relationship to patient and attach a copy of the conformed court guardianship

Witness: _____ Date: _____

Name: _____ Phone: _____