HEARING ASSOCIATES
250 South Crescent Drive, Suite #100
Mason City, IA 50401
(641) 494-5180
(800) 621-6424

RELEASE OF INFORMATION – Patient Authorization

_____ _____
Patient Name (Print) Date of Birth

_____
Social Security Number

I AUTHORIZE INFO TO BE RELEASED FROM: RELEASE INFO TO:

_____
NAME

_____
ADDRESS

_____
CITY STATE ZIP

Medical Information Required:

____ AUDIOGRAMS _____ OTOLARYNGOLOGY

Purpose of Release:

____ TRANSFERRING MEDICAL CARE ____ REFERRAL

____ OTHER _____

_____

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**
(PATIENTS OVER 18 MUST SIGN OWN RELEASE)

_____
RELATIONSHIP, IF NOT PATIENT