Dr. Ha-Sheng Li-Korotky • AuD, PhD, MD • Chief Audiologist • President • CEO

Date _____ **Time** _____ **File#** _____

Requests for Release of Medical Records

Patient Name_____Date of Birth_____SSN_____

Address_____Phone_____

1. I hereby authorize Pacific Northwest Audiology to release information from my medical record to

2. Name_____

Address_____

For the purpose of (please check one)

_____Continued Treatment _____Legal Review _____Insurance purpose_____Personal review of information _____

_____Other (please specify)

3. I limit the information to be released to the following items: (Please check specific items)

_____ Diagnostic tests and results_____Consultation _____ Treatment plan_____Other (please specify)

Covering records from on or about (Date)_____to (Date)_____

4. ***This authorization will automatically expire within six months from the date of signature***. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Pacific Northwest Audiology. I understand that the revocation will not apply to information that has already been released in response to this authorization.

5. I also understand that I have the right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

6. I also understand that in an effort to prevent unauthorized re-disclosure Pacific Northwest Audiology attaches a notice when sending out records that states, "**re-disclosure is prohibited**". However, the potential for an unauthorized re-disclosure may not be protected by federal confidentiality rules.

7. I also understand that in order to process this request to reproduce medical record information on a timely basis, Pacific Northwest Audiology, in which I am requesting information from, may utilize a photocopy service and my signature authorizes the release of information to such photocopy service for the purpose of satisfying this request.

Signature (Patient/Representative/Legal Guardian)_____Date_____

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