Medical Records Release Authorization

Authorization to use, disclose, and obtain protected health information for treatment with the Ear Research Foundation.

Patient Name: ________________________________DOB_____________

(   ) Send Records to   (   ) Obtain Records From

Name of facility or person: _______________________________________

Address: _______________________ City _______________ Zip_________

Telephone #: ___________________________ Fax #: __________________

Records being requested: ( ) Hearing Tests Only

Comments: ____

Requested by: ___________________________Date __________________

Tele: 941.800.3651   Email: Concierge@EarRF.org

Patient Signature: ________________________ Date____________________

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