SHOW LOW
2600 S. White Mountain Rd.
Show Low, AZ 85901
Phone: (928) 537-3456
Fax: (928) 537-3469

Audiology, Inc.
HEARING & BALANCE SERVICES

SAFFORD
620 S Central Ave, Ste B
Safford, AZ 85546
Phone: (928) 428-1613
Fax: (928) 428-0055

REQUEST FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, _____ authorize
(Name of patient) (Date of Birth)

_____ to disclose to **Audiology, Inc.**
(Name of person/organization)

By Fax: (928) 537-3469 by this date:_____

the following information: _____

_____
(Nature and amount of information to be disclosed)

The purpose of the disclosure authorized in this consent is to: _____

_____
(Purpose of disclosure, as specific as possible)

I understand that these records are protected under federal regulations, and the Health Insurance Portability and Accountability Act of 1996, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form. Dated: _____

_____ _____
(Signature of patient) (Signature of person signing form if not patient)

Describe authority to sign on behalf of patient: _____