

**Cary Audiology Associates, PLLC**  
115 Parkway Office Court, Suite 100  
Cary, North Carolina 27518  
Phone: 919 851-3800 Fax: 919 851-3803

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home telephone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Name and Address of Covered Entity **authorized to release** information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name and Address of Covered Entity **authorized to receive** information:

**Cary Audiology Associates, PLLC**  
**115 Parkway Office Court, Suite 100**  
**Cary, North Carolina 27518**  
**Phone: (919) 851-3800 Fax: (919) 851-3803**

Description of Information to be released:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This authorization shall be in force and effect until the information has been forwarded as requested.

Rights of the Patient:

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the above address and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to \_\_\_\_\_.

Signature of Patient or Patient's Representative \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Patient or Representative: \_\_\_\_\_