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:

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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: ____