

## AUTOHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

*Please print all information except for signatures*

(Patient Name) \_\_\_\_\_ born on \_\_\_\_\_, hereby authorizes (or the patient's personal / authorized representative authorizes) the disclosure of records by Kaw Valley Hearing to:

Me (Patient or personal / authorized representative only. Must provide proof of relationship.)

Other / Facility (List full name and address) \_\_\_\_\_

I authorize \_\_\_\_\_ to release the below indicated medial reports to Kaw Valley Hearing.

**Please  
Check  
All Boxes  
Which  
Apply**

- Clinic Notes     Lab Tests     Medications     Consultation Reports     Operative Reports  
 Billing Records     Psychological Reports     Radiology Reports     Diagnostic Studies  
 Specific Dates from: \_\_\_\_\_ to: \_\_\_\_\_ (this helps to ID your specific request)  
 Complete Medical Record or treatment provided at Kaw Valley Hearing  
 Other (Please specify): \_\_\_\_\_

(If you have any questions as to what is included in any of the above categories, prefer an electronic copy of any electronic records, or do not want a specific report released, please let us know at the time of submission.)

The purpose of this request is:  Continued Care     Insurance/Disability\*     Litigation\*     Personal\*     Other\*: \_\_\_\_\_

**\* Kaw Valley Hearing Copy Charges: \$10.00 Base Fee plus \$0.50 per page**

- I understand once the above records are disclosed, they may be re-disclosed by the recipient and may no longer be protected by State and/or Federal Privacy Laws.
- My treatment cannot be conditional upon completing this authorization form, unless the treatment is for the sole purpose of creating information for discloser to a third party.
- I understand that I may revoke this authorization in writing by notifying th original recipient of this authorization at any time except to the extent that action has been taken in reliance on it.

SPECIFY THE DATE, EVENT, OR CONDITION UPON WHICH THIS AUTHORIZATION EXPIRES: \_\_\_\_\_

(In all cases this 'Authorization' will expire one year from the date listed below)

SIGNED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Drivers License Number

\_\_\_\_\_  
State

\_\_\_\_\_  
Signature of Patient or Authorize Representative

\_\_\_\_\_  
Printed Name of Patient/Representative & Relationship

Address: Street # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_  
Daytime Phone Number