AUTHORIZATION AND CONSENT TO RELEASE
AND DISCLOSE
MEDICAL INFORMATION

THE UNDERSIGNED HEREBY AUTHORIZES AND CONSENTS TO THE RELEASE AND DISCLOSURE OF MEDICAL INFORMATION.

1. **Name of institution to make disclosure:**

2. **Name of institution, facility, provider, or person to whom disclosure is to be made:**
   Bayside Audiology, 429 SE Marlin Avenue Suite A Warrenton, OR 97146

3. **Name of patient** ____

4. **Purpose for which disclosure is to be made:**
   Collection of accounts receivable ______ Further medical care ______
   legal purposes ______ Other, specify ______________________

5. **Describe what information is to be disclosed:**

6. **(A) This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon, and a specification of the date event, or condition upon which it will expire without express revocation.**

   (B) This consent expires: 90 (Ninety) days from date of signature

7. **Date and time consent signed:** ______________________________________

8. **I recognize that the information disclosed may contain information that is protected by federal and state law (drug/alcohol abuse; mental health) and I specifically consent to disclosure of such information.**

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Patient's Signiture

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Other person authorized to sign for patient (include relationship)