



East Mountain Hearing
and Balance

**Authorization for Release
of Medical Information**

7007 Wyoming Blvd N (66006) W H %
Albuquerque, NM 87109
Phone: (505) 217-0912 | Fax: (505) 217-0913
eastmountainhearing.com

I authorize _____ to release from the medical record of:

Full Name: _____
(please print)

Date of Birth: _____

Current Address: _____
_____ Phone #: _____

the following information (to include office notes): _____

Send to: _____

Address: _____

Phone #: _____ FAX #: _____

>@YLD)S;

I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to the disclosure of the above information to those persons or agencies named above. I hereby release (DVWRXQWDLQ) +HDULQJ from all legal responsibility or liability that may arise from the release of these WV medical records. I understand that I may revoke this authorization at any time (except retroactively) and this authorization will remain in effect until I offer a written request/authorization for it to be revoked.

Patient Signature: _____ Date: _____