East Mountain Hearing
and Balance

Authorization for Release of Medical Information

7007 Wyoming Blvd N□(□□□□□6□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): _________________________________

____

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Send to: ____

Address: ____

Phone #: ____________________________ FAX #: _______________________________

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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 □(□D□V□W□□□0□R□X□Q□W□D□L□Q□□ □+□H□D□U□L□Q□J□□□□□ from all legal responsibility or liability that may arise from the release of these 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: _______________________