ALLISON AUDIOLOGY
& HEARING AID CENTER, P.C.
Your Hearing Experts

PERMISSION TO RELEASE PATIENT INFORMATION

I, ______________________________, authorize Allison Audiology to release and/or discuss my records with the following recipients:

Primary Care Physician (PCP) Name: ______________________________________

PCP Contact Information (if known): ____

Additional Recipients: _______________________________________

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X____ ____________________________

Signature Date

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. Allison Audiology and Hearing Aid Center, P.C., its employees, officers, and physicians are hereby released from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.