Life Hearing Solutions, PLLC
110 B Town Commons Drive
Shelby, NC 28152
Phone: 704-313-0204 • Fax: 704-313-0194

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____ Date of Birth: _______________________
Address:____
City: _________________________________ State: ________________ Zip:________________
Home telephone: _______________________ Work: _____________________ Cell:__________________

Name and Address of Covered Entity authorized to release information:

Name: ____

Address: ____
City: ________________________________ State: ___________________ Zip: _______________
Phone: _________________________________ Fax: _______________________________

Name and Address of Covered Entity **authorized to receive** information:

Life Hearing Solutions, PLLC
110 B Town Commons Drive
Shelby, NC 28152
Phone: 704-313-0204 • Fax: 704-313-0194

Description of Information to be released:
____
____
____

This authorization shall be in force and effect until the information has been forwarded as requested.

Rights of the Patient:

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the above address and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to ____.

Signature of Patient or Patient's Representative_____________________________________Date: _____________

Print Name of Patient or Representative: ____