



RELEASE/SHARING OF MEDICAL RECORDS WITH FAMILY/LOVED ONES

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This authorization shall be in force and effective until you indicate in writing you no longer wish the family member to have medical or billing information.

I authorize/allow Hearing Dynamics LLC to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

Signature: _____ Date: _____