Link Audiology

AUDIOGRAM AND RELATED RECORDS RELEASE
From Link Audiology

Patient Name: _____ DOB: _____

Address: _____

_____

I authorize Link Audiology to release a copy of my audiogram and related hearing healthcare records associated with the above patient to (initial):

_____ Physician (other than referring) _____

_____ Other Health Professional _____

_____ School _____

_____ Family Resource Coordinator _____

_____ CDHC _____

_____ Other _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notice to Link Audiology, LLC. I understand that if I revoke the authorization, the revocation will not apply to information that has already been released by this authorization or to information that Link Audiology, LLC. has already used based on this authorization. If I have questions about the use and disclosure of my information, I can contact Link Audiology, LLC. at (360) 551-4800.

_____ _____

Signature Date

_____

Printed Name

_____

Relationship to Patient (If Applicable)