

**TRIANGLE HEARING SERVICES, P.A.**

1100 NW Maynard Road  
Suite 130, Cary NC 27513

Ph: 919.363.3006 Fax: 919.342.0817

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**Authorization to RELEASE Health Information**

**1. PATIENT INFORMATION**

Name of Patient		DOB
Address:		
Phone:		

RELEASE INFORMATION FROM:

*Triangle Hearing Services, P.A. 1100 NW Maynard Rd, Suite 130, Cary, NC 27513*

**2. FORWARD INFORMATION TO:**

Practice Name	
Address	

**3. THE RELEASED INFORMATION BELOW WILL BE USED FOR PATIENT CARE.**

<input type="checkbox"/> Audiograms	<input type="checkbox"/> Office Notes	<input type="checkbox"/> Other
Other Information to Include:		

**This authorization shall be in 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 all 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 address above 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.

**1. PLEASE SIGN & DATE**

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