Donella Hellenkamp, Au.D. **Radhika Gupta, Au.D.**

Authorization to RELEASE Medical Records

Name of patient_____ DOB _____

Address _____City, State, Zip_____

I hereby request _____
to release all records, reports, test results and any other data or information pertaining to the condition and treatment of Hearing/Audiology to:

Triangle Hearing Services, P.A.,
1100 NW Maynard Road, Cary, NC 27513
Office: 919-636-3006
Fax: 919-342-0817

_____ _____
Please Print Patient or Personal Representative Date

_____ _____
Patient or Personal Representative Signature Relationship to Patient

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 Information disclosed as a results of this authorization may be subject to redisclosure 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.

_____ Date_____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)