Authorization for Release of Medical Records

I hereby authorize _____ to disclose the following information to the SH Medical from the health records of:

Patient Name: _____ **DOB**: _____

Covering the period(s) of healthcare: From: _____ To: _____

Information to be disclosed:

- ❑ Complete Health Records(s)
- ❑ Hearing aid(s) information
- ❑ Operative Report(s)
- ❑ ER/Discharge Report(s)
- ❑ Laboratory Report(s)
- ❑ Radiology Report(s)
- ❑ Audiogram(s)
- ❑ Other (please specify): _____

This information will be disclosed to SH Medical. Please mail or fax to:

SH MEDICAL
191 SAND CREEK RD, SUITE 125
BRENTWOOD, CA, 94513
PHONE (415) 362-5443 FAX (415) 362-5444

Please transfer requested information by this date: _____

I understand this authorization may be revoked in writing in at any time, except to the extent that action has been taken in in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

SIGNATURE: _____ (patient or guardian) **DATE:** _____

If legal guardian, please state relationship to patient: _____