
# Authorization for Release of Medical Records

I hereby authorize SH Medical to disclose the following information to _____ 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)
- ❑ Other (please specify): _____
- ❑ Laboratory Report(s)
- ❑ Radiology Report(s)
- ❑ Audiogram(s)

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: _____

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