MOUNTAIN AUDIOLOGY
61 Haywood Park Drive, Suite B
Clyde, North Carolina 28721

Release of Information

I, ____ (___/___/_____), authorize
Patient Name Birth date

the release of my ____
Desired Health Information

from:

____
Practice Name

____
Practice Address

to be released to:

____
Practice Name

____
Practice Address

This authorization expires one year from the date below. This authorization may be revoked in writing at my request. I understand charges for duplicating my records may be incurred.

______________________________________ Date: ____________
Signature of patient/parent/guardian

____
Patient's Address

____

Witnessed by: ______________________________________

Date: ___/___/_____