ALLIED HEARING
Always Hear for You

Medical Information Release Form

Allied Hearing
1290 E Broomfield St
Mount Pleasant, MI 48858
Phone: (989) 773-1209
Fax: (989) 773-4267
www.alliedhearing.com

Patient Name:
Date of Birth:
Preferred Name:
Gender:
Address:

Primary Phone:
Secondary Phone:

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to disclose this information to anyone without the patients consent. If you wish to have your medical or billing information released to anyone other than yourself you must sign this form. Signing this form will only give information to the individuals listed below. I authorize Allied Hearing to release my medical and/or billing information to the following individual(s):

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipients is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing.

Patient Signature:_____

Date:_____