EAR-Central, PLLC
Specialists in Auditory Processing

EAR-Central, PLLC/ Release of Medical Records Request
Michael O. Webb, M.S., CCC-A, FAAA / Neuro-Audiologist
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Consent for the Release of Confidential Information:

Patient Name: _____ **Date of Birth:** _____

I, authorize _____ to release the following information to **EAR-Central, PLLC / Michael O. Webb, M.S., CCC-A, FAAA** at the above address:

Information circled or listed below:

- Audiology/ hearing test/ hearing aid records.
- Educational, (Neuro) Psychological, Speech-Language, Other therapy records.
- Neurological, Otological (ENT), or other Medical Information relevant to hearing or CAPD assessment/management.
- Other:_____

I understand that these records containing protected health information (PHI) are protected under federal regulations, and the Health Insurance Portability and Accountability Act of 1996, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by written notice, which shall not apply to PHI obtained or released by this consent prior to such revocation. (*Choose one option below*)

- I do not choose to specify an expiration date, event or condition at this time. _____ (Initials)
- Expiration of this consent shall occur: *Please specify date, event or condition of expiration below*

_____

I understand that I may be denied services if I refuse to consent to a disclosure of PHI for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse consent to a disclosure for other reasons.

I have been provided a copy of this form. _____(Initials) _____ (Date)

Circle One

Signature: _____ (Patient / Other Authorized Signer)

Date signed:

Authority to sign on behalf of patient: _____