

**AUTHORITY TO RELEASE MEDICAL INFORMATION**

I am hereby requesting a release of my records concerning diagnostic studies, recommendations, and other data pertinent to my evaluation and treatment.

**RELEASE FROM:** Audiology Hearing Care Services  
Martinsburg, WV or Charles Town, WV

**RELEASE TO:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF PRIVACY POLICIES AND PRACTICES**

The Communication Policy of Audiology Hearing Care Services Inc. is to provide excellent communication with our patients. To accomplish this, we communicate in various methods: phone calls, emails, mailings, etc. It is within your right under Federal Privacy Policy to restrict such communications. Please read and answer the following statements:

**Messages may be left on my answering machine, if I have one** YES NO

**Messages may be left with others, family members, etc. if they answer** YES NO

**I may be called at work if that number has been provided** YES NO

**Correspondences may be mailed to my home** YES NO

I, (print your name) \_\_\_\_\_, have received a copy of the Notice of Privacy Policies of Practices for Audiology Hearing Care Services.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_