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Magnolia Hearing Medical Release

Patient Name_____

Social Security Number: _____ DOB:_____

Release Records From:	Release Records To:
_____	_____
_____	_____
_____	_____
_____	_____

Healthcare Coverage Period: from _____ to _____

Health Records requested:

( ) Chart Notes

( ) Hearing Tests

( ) Other _____

I understand that specific information to be released may include AIDS or HIV, Alcohol, and/or Drug Abuse and Mental Health issues. I accept responsibility for the release of these documents and information contained herein. Unless otherwise indicated, this authorization will expire one year from the date of this signature. Magnolia Hearing LLC and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance on this authorization for the purposes stated above. I understand that there may be a fee for preparing and furnishing this information.

_____	_____	_____
Signature	Relationship	Date