



250 South Crescent Drive
Mason City, IA 50401
Ph: 641-494-5180
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RELEASE OF INFORMATION – Patient Authorization

Patient Name (Print)

Date of Birth

Social Security Number

I AUTHORIZE INFO TO BE RELEASED FROM:

RELEASE INFO TO:

NAME

Hearing Associates
250 South Crescent Dr, Ste 100
Mason City, IA 50401

ADDRESS

PHONE

CITY

STATE

ZIP

Medical Information Required:

___ AUDIOGRAMS

___ OTOLARYNGOLOGY

Purpose of Release:

___ TRANSFERRING MEDICAL CARE

___ REFERRAL

___ OTHER

EXPLANATION IF OTHER: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN
(PATIENTS OVER 18 MUST SIGN OWN RELEASE)

DATE

RELATIONSHIP, IF NOT PATIENT