Good Sound Audiology, PLLC

Authorization for Release of Medical Information

Patient Name:_____DOB: _____
Address:_____
City:_____State:_____Zip Code:_____
Home:_____ Work:_____ Cell:_____

☐ **I authorize Good Sound Audiology to release information to:**

☐ **I authorize Good Sound Audiology to release information from:**

_____
Name of provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # *Fax #*

I hereby consent to the release of the specified information relating to audiological analysis, treatment, condition, follow up, or dates of treatment. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to authorize the release of patient health information to Good Sound Audiology.
I understand my right to healthcare treatment is not based on the condition of this authorization and I have the right to refuse to sign this authorization. I understand that I have the right to revoke this authorization by sending a written notification to the facility.

Patient Name Printed_____
Patient Signature_____Date_____
Parent/Legal Guardian_____Date_____

201 W. Guadalupe Rd., Ste. 315, Gilbert, AZ 85233 (480) 497-0780
10450 E. Riggs Rd., Ste. 116, Sun Lakes, AZ 85248 (480) 883-2842
6816 E. Brown Rd., Ste. 102, Mesa, AZ 85207 (480) 634-6100