VIRSONO
Hearing Center

1901 Floyd Street
2nd Floor
Sarasota, FL 34239
(941) 259-1177

Authorization to Release Medical Records

Patient Name _____ DOB _____

I, the undersigned, authorize the below listed practice to furnish to Virsono Hearing Center with copies of the information listed below:

Practice Name _____

Information to be released:

- ✓ Hearing Health History
- ✓ Audiogram(s)
- ✓ Health Information and Chart Notes Relating to My Hearing

The above party may disclose this health information to Virsono Hearing Center via email or fax. Please email to SarasotaFL@virsonohearing.com or fax to; (941) 259-1177. This information may be used by Virsono Hearing Center for medical treatment or consultation, billing or claims payment, or other purposes I may direct. This authorization will expire in six months.

I understand that I may revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that disclosers made based upon my original permission cannot be taken back and that revocation is not effective to the extent that disclosure made in good faith has already occurred in reliance on this authorization. I understand that it is possible that information disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Patient Name _____ Date: _____

Relationship to Patient if other than self _____

Patient Signature _____