SILVER STATE
HEARING & BALANCE

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **Silver State Hearing and Balance** to release healthcare information of the patient named above to:

Name: Hoosier Service Inc.

Address: 18032 Lemon Dr.,#C-618

City: Yorba Linda State: CA Zip Code: 92886

Phone:800.882.4156; Fax:800.882.4957

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ All healthcare information

☐ Other: _____

Definition of Medical Records: Audiogram, Tympanogram, Tinnitus Evaluations, Vestibular Evaluations, Hearing aid related items, CI programing and any other records that pertain to my ear health obtained by **Silver State Hearing and Balance**. All records that are obtained by **Silver State Hearing and Balance** from another healthcare entity will not be released as those records are not part of **Silver State Hearing and Balance's** records.

I understand that **Silver State Hearing and Balance** may charge a reasonable fee for copying the records, but will not charge for time spent locating the records. If the request of the records are to be mailed, I may be charged for postage.

I understand that **Silver State Hearing and Balance** has 30 days as specified under HIPPA to release the records. If the records request cannot be honored within 30 days **Silver State Hearing and Balance** will inform me by letter with an expected date the request will be completed.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.