Audiology
of Greenville, New Bern, and Wilmington

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

We provide you with important diagnostic information about your hearing. We feel it is important for your physician to have this information for your medical records. **I give my permission for Audiology of Greenville, New Bern, and Wilmington to obtain and release my medical records so that they can better understand my condition and help me.** This release will be in effect until we receive a written notice from you requesting we may no longer forward this information.

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PATIENT/GUARDIAN'S SIGNATURE **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that **I may request a copy** of Audiology of New Bern's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and the website.

- This Notice informs me how Audiology of Greenville, New Bern, and Wilmington will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Audiology of Greenville, New Bern, and Wilmington may use and share my health information for other than treatment, payment, and health care operations.
- Audiology of Greenville, New Bern, and Wilmington will also use and share my health information as required/permitted by law.

_____

PRINT NAME of patient or guardian

_____

SIGNATURE of patient or guardian

_____

DATE

Audiology of Greenville
1702 East Arlington Blvd. Suite F
Greenville, NC 27858

Audiology of New Bern
2111 Neuse Blvd. Suite I
New Bern, NC 28560

Audiology of Wilmington
1121-H Military Cut Off R
Wilmington, NC 28405