pacificaudiologyclinic

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3502 NE Broadway | Portland, OR 97232 | **(503) 284-1906**
www.pacoregon.com

Permission to Release Medical Record

Patient Name: _____ Date of Birth: _____

Former Name(s): _____ Social Security _____

I hereby authorize the release of information

To:

☐ Pacific Audiology Clinic
3502 NE Broadway Street
Portland, Oregon 97232

☐ Pacific Audiology Clinic-West
5331 SW Macadam Avenue
Portland, Oregon 97239

From:

For the following dates of service: _____

The purpose of the release is:

☐ Diagnostic Evaluation ☐ Follow up
☐ Reimbursement ☐ Other _____

The following information is requested and may be released: (please check all that apply)

- ☐ All Records
- ☐ Progress Notes
- ☐ Audiology/Hearing Tests
- ☐ Other _____

I do ☐ , do not ☐ specifically consent to the transmission of my medical records via fax machine.

_____ _____
Signature of patient or representative Relationship

_____ _____
Date Signed Witness