Lyric Audiology, PLLC

371 State Route 17M, Suite 7
Monroe, NY 10950
(845) 395-0300

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

NAME:_____

BIRTH DATE: _____

SOCIAL SECURITY NUMBER:_____

To:_____

I authorize and direct you to release my medical records/medical information from (dates) _____ to _____ for the purpose of continuity of medical care.

Please send or fax my records to:

Name:
_____

Address:
_____

_____

Fax Number: _____

Phone Number:_____

I understand that I may revoke this consent at any time and that this consent will automatically expire 90 days from the date signed below. This hereby releases the sender from all legal responsibility or liability which may result from the release of my medical records.

Date: _____

Signature: _____
(you or authorized representative)

Witness: _____