DeSoto EYE & EAR

Authorization for the Release of Medical Information

IMPORTANT: READ ALL INFORMATION ON THIS FORM BEFORE SIGNING.

Patient Name _____ Birthdate _____ /_____ /_____
MM DD YYYY

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
_____ Organization/Person Name _____ Street Address City, State, Zip _____ Phone Fax	Desoto Eye & Ear LLC 5740 Getwell Road, Building 3, Unit B Southaven, MS 38672 Phone: (662) 510-2138 Fax: (662) 510-2962

This request and authorization applies to information relating to audiological analysis, treatment, condition, follow-up or dates of treatment.

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above-named person or organization. You have the right to revoke or cancel this authorization in writing at any time.

Patient Signature _____ Date _____

Parent or Legal Guardian _____ Date _____

Relationship To Patient, If Other Than Patient _____

Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.