



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 New Bern 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.

\_\_\_\_\_  
**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 New Bern 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 New Bern may use and share my health information for other than treatment, payment, and health care operations.
- Audiology of New Bern 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**