ADVANCED
AUDIOLOGY & HEARING AIDS, LLC

Authorization for release of medical record information from an outside facility

Patient Information:

Last Name: _____ First Name: _____ Date of Birth: ____ / ____ / ____

Street Address: _____ Apt/Ste #: _____

City: _____ State: _____ Zip: _____

Telephone (H): _____ (W): _____ (C): _____

I _____ , am under the care of Advanced Audiology & Hearing Aids, LLC.
I hereby authorize the provider named below to transfer my medical records to Advanced Audiology & Hearing Aids, LLC, doctor and location as indicated.

(Please fill in the name and the complete address of the outside facility and provider from whom information is being requested)

Doctor: _____ Practice Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Please send the requested information to Advanced Audiology & Hearing Aids, LLC to the attention of:

AAHA Audiologist: _____

1503 Goodwin Rd., Suite 205

Ruston, LA 71270

FAX: 318-202-3197 EMAIL: Audiology@RustonHearing.com

Description of information to be enclosed:

_____ All Records _____ Audiograms _____ Hearing Aid Information _____ ENT Reports _____ MRI Reports _____ Insurance

Dates of treatment: _____

Other: _____

Reason for requested Information disclosure:

☐ Transfer of health coverage ☐ Personal Use ☐ Form Completion ☐ Referral ☐ Change of healthcare provider

Patient signature: _____ Date: _____

Signature of patient representative: _____ Date: _____

Jerrilyn Frasier, Au.D., L-SLP/A

1503 Goodwin Rd., Suite 205, Ruston, LA 71270
Phone: (318) 251-1572