Clarke Schools
for Hearing and Speech

Medical Record Release

Authorization to Disclose Protected Health Information

I hereby request a copy of the following patient's medical record:

Name: _____

Address: _____

Date of Birth: _____

Information Requested

Date of appointment or hospital stay beginning _____to _____

_____ Entire Record	_____ Emergency Department	_____ Progress Notes
_____ Out Patient	_____ Inpatient	_____ Immunization Record
___X_ Audiological Reports	_____ Operative Reports	_____ Radiological Reports
_____ Discharge Summary	_____ Home Care	_____ Nurses Notes

_____ Other Information (please specify) _____

If there is any part of the record you do not wish released, please indicate here: _____
If you records contain any information about substance (drug or alcohol) abuse, HIV, or mental health, may this information be released? If yes, please initial next to each type of information to be released:
Drug and/or alcohol treatment or testing _____ HIV _____ Mental Health _____

The above record(s) are to be released to: Clarke Schools for Hearing and Speech
455 S. Roberts Road
Bryn Mawr, PA 19010
610-525-9600

Expiration: Your permission will expire on : _____8/31/2017_____. If you wish to indicate a different date you're your permission to expire indicate it here:_____.

Understanding this Authorization: This allows the release of information that exists in the patient's medical record when the form is signed, as well as information created after the form is signed until it expires. I may withdraw my permission at any time by providing written notice to Clarke Schools for Hearing and Speech. If I withdraw my permission, any information that was already released cannot be retrieved.

Signature: By signing I understand that I am authorizing _____
to release information as described above. (Name of Facility/Physician)

_____ **Date**: _____
Signature

_____
Print Name