Pacific Northwest Audiology

Medical Record Release Form

Patient Name _____ F / M D.O.B. _____

Last First M.I.

Requests the release of medical records relevant to audiology diagnosis and treatment.

Requests that the medical records be transferred

To:

Pacific Northwest Audiology, LLC

2205 NW Shevlin Park Road, Bend, OR 97702

Phone: (541) 678-5698

Fax: (541) 306-4552

Email: info@pnwAudiology.com

From:

Clinic _____

Physician / Audiologist _____

Phone _____

Fax _____

Email _____

Records being requested:

- ☐ Previous audiological test results
- ☐ Reports
- ☐ Hearing aid information
- ☐ Cochlear implant mapping information
- ☐ BAHA programming information
- ☐ Sound therapy records
- ☐ MRI reports
- ☐ Surgical records (ear, hearing and balance related)
- ☐ Medications

Signature of Patient or Guardian _____ **Date** _____