Colorado Tinnitus
and Hearing Center, Inc.
Connecting People With The Sounds of Life

Colorado Tinnitus & Hearing Center, Inc.
3601 South Clarkson Street, #220
Englewood, Colorado 80113
PH: 303.534.0163
F: 303.534.0179

Authorization for Request of Medical Records

Patient Name: _____Date of Birth: _____

Phone Number: _____ Email Address:_____

Recipient Information (Who Should Receive the Records):

- ☐ Colorado Tinnitus & Hearing Center, Inc.
- ☐ Patient
- ☐ Insurance Company
- ☐ Legal Representative
- ☐ Other:_____

  Phone:_____ Fax:_____

Records Requested (Check All That Apply):

- ☐ Audiology Reports
- ☐ Hearing Test Results
- ☐ Tinnitus Evaluation
- ☐ Treatment Plans
- ☐ Other: _____

I authorize Colorado Tinnitus & Hearing Center to request my medical records as specified above. I understand that:

- My records are protected under federal and state confidentiality regulations (HIPAA) and cannot be disclosed without my written consent.
- I may revoke this request at any time in writing, but the revocation will not apply to records already released.
- I may be responsible for processing fees associated with copies of my records.

This authorization expires one year from the date signed unless specified otherwise.

Patient Name:_____ Date of Birth: _____

Patient / Guardian Signature: _____ Today's Date:_____