As per Federal and HIPAA regulations, you are permitted to request that a copy of your patient file be forwarded to other physicians, persons, facilities, and entities. Upon receipt of this signed request, we will forward to you a copy of your medical record.

Signed releases can be faxed to: (717) 646-9322

Signed releases can be mailed to:
Keystone Hearing Institute
250 Fame Avenue, Suite 222
Hanover, PA 17331

Signed Releases can be personally delivered to:
Keystone Hearing Institute
2151 Linglestown Rd., Suite 130
Harrisburg, PA 17110

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize The Keystone Hearing Institute to release confidential health information about me, by releasing a copy of my medical (hearing healthcare) records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: ______________________________ Date of Birth:_____________

The information released will include all patient documentation to include test results, progress notes, and professional correspondences.

Release my protected health information to the following physician, person, facility, entity and/or those directly associated with my medical care:

Name: _______________________________________

Address:______________________________________

City:_________________________________ State: _____ Zip Code:__________

_____________________________________ _________________________

Patient Signature Date
Parent/Guardian if patient under 18