AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

TO: Hospital/Clinic/Doctor's office

Insert Name of Hospital/Clinic/Doctor's Office from whom records are requested:	
Address:	
City/State/Zip:	
Phone #:	Facsimile #:
Email:	
RE: Patient's Name	Date of Birth:
Address:	
City/State/Zip:	
Patient's Phone #:	

I authorize the hospital/clinic/doctor's office listed above to release my health information identified in this form to:	
Otologic Management Services (OMS), a division of Cochlear Americas	
13059 East Peakview Ave, Centennial, CO 80111	
Phone #: 800-633-4667, option 4	Facsimile #: 303-524-6765
Email: reimbursement@cochlear.com	

Purpose of this Request: Insurance coverage assistance

Type of Records Requested:

- All medical records related to my hearing loss OR
- Treatment Summary (includes history/physical, audiograms, x-ray reports, operative reports)

This request does not include a request for any records not related to the above two types of records and OMS specifically asks that no other health records be provided.

This Authorization is valid for 1 year from the date of this authorization OR until ____________ (insert date).

I understand that:
• My right to healthcare treatment is *not* conditioned on the authorization.
• I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except when a disclosure has already been made in reliance on my prior authorization.
• If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
• Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

Signature of patient or authorized representative of patient: ________________________________

Date_______________

Relationship to Patient (*If requester is not the patient*)______________________