HEAR FOR YOU
HEARING & BALANCE CENTER, LLC

# Patient Authorization to Disclose Health Information

I _____ authorize Dr. Rachel Baboian
Patient First Middle Initial Last

at Hear For You Hearing and Balance Center, LLC to use and disclose any diagnostic testing, reports, and warranty information to:

_____
Individual/Provider Seeking Information

_____
Name of Practice

_____
Address

_____
City State Zip Code

( ) ( )
Phone Number Fax Number

This authorization for release of information is effective from:

_____ to _____

Personal Representative or Patient's Signature: _____

Print Name of Patient OR Representative and Relationship to Patient: _____

Date: _____