HEAR FOR YOU
Audiology & Hearing Aid Services

Patient Authorization to Disclose Health Information

I _____ authorize the providers
Patient First Middle Initial Last

at Hear For You Audiology & Hearing Aid Services 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: _____