HEARING & BALANCE CENTER

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I hereby authorize:

Hearing & Balance Center, PC
233 East Erie Street, Suite 505
Chicago, Illinois 60611

Hearing & Balance Center, PC
715 West Hillgrove Avenue
LaGrange, Illinois 60525

To release any and all medical records regarding hearing, tinnitus and/or balance evaluations from _____to _____
(date) (date)

FOR:_____ _____
PATIENT'S NAME: First, Middle, Last DATE OF BIRTH

_____
PATIENT'S ADDRESS:

_____

_____

for the purpose of continued medical and/or audiologic care.

TO: _____

_____

_____

This authorization will remain in effect a maximum of six months from the date of signature and may be cancelled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy or electronic digital copy of this authorization will be treated in the same manner as the original.

DATE: _____ SIGNATURE OF PATIENT/GUARDIAN_____

HEARING & BALANCE CENTER

RELATIONSHIP TO PATIENT _____

WITNESS: _____ **REASON PATIENT IS UNABLE TO SIGN**_____
(OPTIONAL)