HEARING CENTER OF PLAINVIEW

AUDIGY CERTIFIED

Authorization To Release Records

Name:_____ DOB:_____

I hereby authorize Hearing Center of Plainview LLC to discuss and send all pertinent diagnostic and/or therapeutic information to my referring physician along with the following doctor(s), facilities, and individuals listed below:

Name:_____Phone/fax:_____

Address:_____

Name:_____Phone/fax:_____

Address:_____

Name:_____Phone/fax:_____

Address:_____

Patient Signature:_____ Date:_____