HEARING CENTER OF PLAINVIEW
Audiologists of Distinction

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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: _____________________________________

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NAME: _____________________________________

Phone/Fax: _____________________________________

ADDRESS: _____________________________________

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NAME: _____________________________________

Phone/Fax: _____________________________________

ADDRESS: _____________________________________

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Patient signature:__________________________________