Release Form

Patient Name _____ Date _____

I, _____ authorize Central Florida Hearing Services, PLLC to release or obtain medical records and all information, including copies of my Hearing Evaluation and any related Hearing and Balance Evaluations, all pertinent hearing aid information, notes and reports to or from:

Information deemed appropriate unless updated in writing.

(1) Name _____

Address _____

Phone _____ Fax _____

(2) Name _____

Address _____

Phone _____ Fax _____

(3) Name _____

Address _____

Phone _____ Fax _____

(4) Name _____

Address _____

Phone _____ Fax _____

_____ _____

PATIENT SIGNATURE DATE