The Hearing Teacher

Supporting Children with Auditory Processing Disorders & Hearing Loss

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client's Name: _____ Date: _____

DOB: _____

I request and authorize the following person(s) or agencies to share confidential information of the patient named above with:

Marcie V. Brown, The Hearing Teacher, L3C
Information may be sent by fax or email to the following:
FAX: 844-884-0938
thehearingteacher@gmail.com

Name	Organization	Contact
	(Audiologist)	
	(School)	
	(Physician)	
	(Other)	

Regarding the following information:

___X___ Audiology Information

___X___ENT/Medical Information

___X___Speech/Language Reports

_____Educational Reports

_____Psychological Reports

Signature: _____ Date: _____

(734) 395-7908 or (269) 312-0321
thehearingteacher@gmail.com
www.thehearingteacher.org