2300 Genoa Business Park Drive · # 130 · Brighton, MI · 48114 · PH.: (810) 225-2205 · FAX: (810) 225-2209

24001 Orchard Lake Road · # 170 · Farmington, MI · 48336 · PH.: (248) 881 – 3026 · FAX: (810) 225 – 2209

CONSENT TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Address:_____

_____

( ) I authorize **THE HEARING CLINIC** to release my _____
_____
_____
_____

( ) I authorize **THE HEARING CLINIC** to obtain my _____
_____
_____

Please send information to:
The Hearing Clinic
2300 Genoa Business Park Drive #130
Brighton, MI 48114
PH.: (810) 225 – 2205 FAX.: (810)225 – 2209

I hereby authorize treatment of myself or my minor child for the purposes of receiving audiometric services by THE HEARING CLINIC. I provide this authorization with full knowledge and informed consent. I authorize THE HEARING CLINIC to release/obtain information to/from any professional consultant involved in planning appropriate medical, educational, or vocational services. I certify the health insurance information provided is valid coverage for the named patient, and authorize payment to be made directly to THE HEARING CLINIC. In addition, I authorize THE HEARING CLINIC to release information to my insurance company or agency for myself or my minor child. I understand that I am financially responsible to THE HEARING CLINIC for charges not covered by this assignment.

_____ _____
Signature of Patient, Parent of Minor, or Legal Guardian **Date Signed**

_____
Witness Signature