SOUND
HEARING & BALANCE

Consent for Release Form

Patient Name _____ Date _____ /_____ /_____
First MI Last MM DD YYYY

_____ I hereby authorize Sound Hearing and Balance to provide audiometric services and make appropriate recommendations to me.

_____ I hereby authorize Sound Hearing and Balance to release any and all information contained in the medical record of the above listed person to any third party payer for whom I seek payment or reimbursement for expenses related to my office visit.

_____I hereby assign and set all insurance benefits to which I am entitled and which are otherwise payable to me to Sound Hearing and Balance.

_____I hereby authorize Sound Hearing and Balance, having treated me, to release information to other health care facilities or physicians involved in my care.

PLEASE INITIAL ALL FOUR STATEMENTS

I also hereby consent to have SOUND HEARING AND BALANCE release to the following persons information about my care and treatment.

1. _____

2. _____

_____ _____
Signature of patient Other authorized signature

_____ _____
Date Relation to patient