THE HEARING CLINIC

Blacksburg • 920 Plantation Rd, Ste 104
540.552.1904

Blacksburg • 830 Davis St, Ste 2
540.315.9859

Salem • 1802 Braeburn Dr
540.772.2669

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize **The Hearing Clinic, Inc.** to release protected health information (diagnosis, Reports, testing and treatment) for myself or _____, DOB: _____ to the following people:

_____ _____

_____ _____

_____ _____

I understand that I may revoke this authorization at any time by notifying **The Hearing Clinic, Inc.** in writing at the address listed below. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

I further understand that this authorization will remain effective from the date of my signature until _____, and that the information will be handled confidentially in compliance with all applicable state and federal laws.

If you have any questions about the use and disclosure of your information, please contact **The Hearing Clinic, Inc.** at the phone number's listed above.

Signature of Patient/Guardian: _____ Date: _____

Printed Name of Patient/Guardian: _____

Signature of Witness: _____ Date: _____