

PERMISSION TO RELEASE MEDICAL INFORMATION

I, _____ hereby give my consent to Peninsula Hearing, Inc. to have access to any pertinent medical records. This may include speaking with and obtaining records from primary care physicians, specialty physicians, psychologists, social workers, and other therapists treating me. I also give Peninsula Hearing, Inc. permission to share any of their medical information with those individuals listed below. This consent is valid as long as Peninsula Hearing, Inc. is providing audiologic services for me.

Signature of patient: _____
(parent/guardian if under age 18)

Date: _____

Dr. _____

Dr. _____

Dr. _____

Family Member: _____

Family Member: _____

Former Audiology Practice: _____

School: _____

Other: _____
