Enjoy the sounds of life!

CONSENT TO EXCHANGE INFORMATION

Patient Name ____ Date of Birth ______________________

Current Address ____

Telephone Number(s) ____

I hereby give my consent for Hear for You Hearing Aid Center, LLC. to exchange information with:

(Name and Address of Agency/Individual)

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Information exchanged may include but is not limited to hearing records and medical reports. Information may be shared through written reports, by phone, fax or in person.

All of the information I hereby authorize to be exchanged with the above will be held strictly confidential and cannot be released without my written consent. I understand that I the right to inspect and copy the information being disclosed. I understand that I may withdraw this authorization at any time through written notice.

This request is effective up to and including 1 year from the date of signature.

☐ By checking this box, you authorize Hear for You Hearing Aid Center to periodically send you, via e-mail or U.S. mail, helpful information relating to your hearing health and maintenance for your hearing instruments, special promotions that may be available to you, and/or information about special fundraising events.

______________________________________ ______________________________________

Signature of Consenting Party

Relationship to Patient
(must be legal guardian/conservator)

Date ______________________________