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1001 Washington Road
Westminster, MD. 21157
410-857-3800

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____

I request and authorize *Healthy Hearing and Balance* to release the information of the patient named above to:

Name: _____ _____

Address: __ _____ _____

City: _____ _____State: _ _____ Zip Code: _____

Phone #: _____ **Fax**#:_____

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____
- All Healthcare information
- Other: _____

Patient Signature: _____Date Signed:_____

This authorization expires ninety days after it is signed