RELEASE OF MEDICAL RECORDS

Patient Name: ______________________________ Date of Birth: ______________

1. **Patient/Guardian Permission for Lake Murray Hearing**

Release Records to Physician:

We provide you with important diagnostic information about your hearing. We fell it is important for your physician to have this information for your medical records. By signing this form you are providing us permission to send a copy to your physician. This Release will be in effect until we receive a written notice from you requesting we may no longer forward this information.

---

2. **Patient/Guardian Permission for Lake Murray Hearing**

To Obtain Records From:____

In order to provide you with the best service possible, we may be required to contact your previous audiologist, ENT physician, hearing aid dispenser, or hearing aid manufacturer for information regarding your hearing, hearing aid, warranty, etc. This release will be in effect until we receive a written notice from you requesting we no longer obtain this information.

___________________________________ ______________________
Patient/Guardian Signature Date