Nancy Hart, Au.D., FAAA, CCC-A
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