Consent for Release of Information

Name of Patient: _____DOB:_____

- **I HEREBY AUTHORIZE** *Comprehensive Hearing Services* to release any and all information contained in the medical record of the above listed patient to any third party payer for whom I may seek payment or reimbursement for expenses related to my office visit.

- **I HEREBY ASSIGN** and set over all insurance benefits to which I am entitled and which I am entitled and which are otherwise payable to me to *Comprehensive Hearing Services*.

- **I HEREBY AUTHORIZE** *Comprehensive Hearing Services,* having treated me, to release information to other health care facilities or physicians involved in my care.

I also hereby consent *Comprehensive Hearing Services* to release information about my care and treatment to the following persons.

1._____

2._____

3._____

4._____

5._____

_____ _____

Signature of Patient or Guardian Date

_____ _____

Printed name of Patient or Guardian Relationship