HIPPA RELEASE and AUTHORIZATION

☐ By checking this box and signing below, I authorize Longhorn Hearing, PLLC to release all medical information to my insurance carrier(s). I also agree to accept financial responsibility for all charges which are non-covered and thus not paid to Longhorn Hearing, PLLC by my insurance carrier(s) for services rendered by Longhorn Hearing, PLLC. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in my being financially responsible for payment in full at the time of visit.

☐ By checking this box and signing below, I authorize Longhorn Hearing, PLLC to release all medical information, including hearing tests, hearing aid information, and medical history to my primary care physician or my referral physician.

☐ By checking this box and signing below, I authorize the semi-invasive procedure of otoscopic examination of my ears, and if needed, cerumen (ear wax) removal and impression taking of my ears. I understand that there is a very slight possibility of discomfort and/or slight abrasion of my ear canals from these procedures.

☐ By checking this box and signing below, I authorize the discussion of my hearing tests, hearing aids, appointment scheduling and medical history between Longhorn Hearing, PLLC staff and my immediate family, which may include my spouse, children, parents, and siblings *(please circle any that apply)*.

Signature of Patient or Guarantor: ____

Printed Name______________________________________**Date**___________________