LONGHORN HEARING PLLC

MEDICAL RECORDS 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).

☐ 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 referring physician.

☐ 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: _____