FAMILY HEARING CENTER

18 Westage Business Center Dr.

Fishkill, NY 12524

Tel: 845-897-3059 Fax: 845-897-3254

RELEASE OF INFORMATION

I hereby authorize the Family Hearing Center to render an Audiological summary report regarding

_____ to: (**List Physician(s) Below**)
(name)

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Patient's Signature
Or Parent/Guardian:_____ Date:_____

SIGNATURE ON FILE

I authorize the release of any medical or any other information needed to process a health insurance claim. I authorize payment of medical benefits to Family Hearing Center for services rendered at this office. I understand that I am financially responsible for any balance not covered by my insurance including **co-pays, deductibles and co-insurance**. **If hearing aids are purchased, the hearing evaluation will be billed separately.**

Patient's Signature
Or Parent/Guardian:_____ Date:_____

NOTICE OF PRIVACY PRACTICE

I acknowledge the receipt of Family Hearing Center's Notice of Privacy Practices by signing below.

Patient's Signature
Or Parent/Guardian:_____ Date:_____

REMINDER NOTICES

I give my permission for Family Hearing Center to send me reminders when I am due for a re-evaluation.

Patient's Signature
Or Parent/Guardian:_____ Date:_____