Acknowledgement Receipt of Notice of Privacy Practice

I have received a copy of this office's Notice of Privacy Practices.

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

Patient Authorization to Disclose Health Information

I ______________________________ authorize Dr. Rachel Baboian

Patient First Middle Initial Last

at Hear For You Hearing and Balance Center, LLC to use and disclose any

diagnostic testing and reports to ______________________________.

Individual/Provider Seeking Information

This authorization for release of information is effective from:

______________________ to ______________________

Personal Representative or Patient's Signature: ______________________________

Print Name of Patient OR Representative and Relationship to Patient: ______________________________

Date: ______________________________