PA Center for Hearing & Balance, LLC

Better Hearing. Better Living.

CONSENT TO OBTAIN RECORDS

Patient Name: _____

Address: _____

_____

Date of Birth: _____

I,_____, hereby authorize PA Center for Hearing & Balance/Liliana C. Piccinini, Au.D. to obtain information contained in my medical records at:

Name: _____

Address: _____

_____

Telephone: _____ Fax: _____

The specific extent or nature of information to be disclosed is:

- ✓ **Records relating to recent Audiograms (hearing tests)**
- ✓ **Records relating to recent hearing aid information**
- ✓ **Records relating to recent Audiograms and hearing aid/devices information**

The authorization is valid only for the information, agencies, corporations, law offices, and persons cited above, and only if received within 90 days after the patient's date of signature on this form. The patient may revoke this authorization at any time, except to the extent that records have already been released pursuant to this release. Any re-disclosure of this information is not permitted without specific authorization of the patient to do so.

_____ _____

Patient, Parent of Minor Patient, or Legal Guardian Signature Date

_____ _____

Signature of Witness Date