Colorado Tinnitus and Hearing Center, Inc.
3601 South Clarkson Street, Suite 220
Englewood, Colorado 80113
Phone 303-534-0163 Fax 303-534-0179
www.helpforringing.com

Connecting People with the Sounds of Life

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

I authorize **Colorado Tinnitus and Hearing, Inc. to** release a copy of my hearing evaluations, audiological tests, medical clearances and other information regarding my hearing loss and/or any hearing related issues.

_____I would like these records released to myself. (Please initial on line).

_____ I would like these records released to my Primary Care Physician. (Please initial and include the name of the physician below).

_____

Name of Primary Care Physician and Phone Number

_____I understand that I may be referred to an Ear, Nose and Throat Physician for further medical evaluation. (Please initial on line).

_____

Name of ENT Physician (if you already see one)

Patient Name: (please print)_____

Patient/Guardian Signature:_____

Date of Birth:_____