HEARING & BALANCE CENTERS OF WEST TENNESSEE
The Jackson Hearing Center

AUTHORIZATION FOR RELEASE OF AUDIOLOGICAL INFORMATION

To:	From:
Fax:	Date:
Phone:	Pages:
Re:	Phone: 731-660-5511
DOB:	Fax: 731-660-4477

THIS WILL AUTHORIZE YOU TO RELEASE AUDIOLOGICAL INFORMATION TO:

The Jackson Hearing Center
172-D University Parkway, Jackson, TN 38305
Phone: 731-660-5511
Fax: 731-660-4477

I would like to request that my records be provided to the above as promptly as possible.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

_____

Patient Signature: _____ Date: _____