NORTHWEST
HEARING + TINNITUS

RECORDS RELEASE AUTHORIZATION

To: _____
PHYSICIAN OR CLINIC NAME

_____ _____
FAX NUMBER *PHONE NUMBER*

_____
ADDRESS

_____ _____ _____
CITY *STATE* *ZIPCODE*

I, _____, hereby authorize and request you to release the following records:

- ☐ Audiograms
- ☐ Hearing Aid History
- ☐ ABR Results
- ☐ Other: _____

To: Northwest Hearing and Tinnitus
Atten: _____
10564 5th avenue NE Suite 203
Seattle, WA 98125
Phone: 206-367-1345
Fax: 206-367-1366

Patient Name: _____

Date of Birth: _____

_____ _____
Patient Signature Date

This request contains confidential information which is intended only for the use of the individual to which it is addressed. Further disclosure of this information is strictly prohibited.