

To:

AUTHORIZATION FOR RELEASE OF INFORMATION
Authorization to release medical and audiological information to:

Premium Hearing Solutions
555 W. 14 Mile Rd. Suite 2A
Clawson, MI 48017
Phone: 248-435-6811
Fax: 248-435-6855

Please send the following information for the following patient:

_____, DOB: _____

- ____ Medical Records
- ____ Audiological Records
- ____ Real Ear Measures
- ____ Extended Warranties
- ____ Chart Notes
- ____ Hearing Aid Specs/Eval.
- ____ Bill of Sale
- ____ Repair form/work orders
- ____ Other: _____

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

Date: _____ Signature: _____