Your HEARING Now INC.	Please email or fax the requested documents to Team@YourHearingNow.com or fax 941-206-2201	Your Hearing Now The Paulson Centre 18245 Paulson Drive, Port Charlotte, FL 33954 Phone 941-564-9780 Fax 941-206-2201 www.YourHearingNow.com Team@YourHearingNow.com

CONSENT TO RELEASE CONFIDENTIAL HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth:_____

Person, agency or provider from whom the disclosure is requested:

Name: _____

Address: _____

Phone: _____

Fax and/or email: _____

Information or records to be disclosed: _____

_____

_____

As the person signing this consent, I understand that I am giving my permission to the above named provider or other named third party for disclosure of confidential healthcare records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure as permitted by law:

This consent expires on: _____

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative