**Colorful Hearing**

**2530 W. University Dr., Ste 1130**

**Denton, TX 76201**

**Phone 940-387-3330  Fax 940-387-3332**

# Authorization for Release of Records

To: ____________________________________________________________

____________________________________________________________

Regarding: ____________________________________________________________

____________________________________________________________

Name of Patient: ____________________________________________________________

Date of Birth: ___________________________

I authorize _____________________________ to issue a copy of my audiogram and related hearing healthcare records to Colorful Hearing.

________________________________________ ____________________

Patient Signature Date

________________________________________ ____________________

Witness Signature Date