RELEASE OF INFORMATION

I hereby request and authorize Hear at Home Mobile Hearing Clinic LTD to release the following medical information.

Please release the following information:

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Please send this information to:
(make sure there is one individual listed and not just a general company name)

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____

NAME

ADDRESS

CITY

PROVINCE

POSTAL CODE

TELEPHONE NUMBER

Authorization must be signed by the patient or by a legal guardian for medical records to be released.

____
Patient/Guardian's Signature & Date