Sound E.N.T. Consultants

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**Olympia**, WA 98502

2601 Cherry Ave., Ste. 317
**Bremerton**, WA 98310

16400 Southcenter Pkwy, Ste 514
**Seattle**, WA 98188

3726 Broadway, Ste. 304
**Everett,** WA 98201

4407 N. Division Street, Ste. 411
**Spokane**, WA 99207

# AUTHORIZATION TO RELEASE INFORMATION

Name: _____

Date of Birth: _____

To:

You are authorized to give Sound ENT Consultants, or its representatives, any information you may have regarding my condition while under your treatment. In addition to your observations, please include: audiograms, records of treatment for hearing loss and noise exposure, medical history, examinations, consultations, X- rays, diagnoses, prescriptions and all other information relating to any disease, injury or other physical condition. This original or a photocopy is acceptable.

I also give Sound ENT Consultants permission to send any audiograms and physician's reports that pertain to my hearing loss to the referring audiologist, hearing aid dealer or physician.

I understand I am releasing these records so that Sound ENT Consultants can administer and process my claim. I understand these records will be treated confidentially in accordance with the laws of the State of Washington (RCW 51.20.070).

I can withdraw this authorization in writing at any time.

_____ _____

Signature Today's Date

Please send the information to:

**Sound ENT Consultants:**

☐ 406 Yauger Way Suite B
Olympia, WA 98502
FAX: 360-754-1628
PH: 360-754-6069