AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ authorize the release of all medical and audiological records from:
Print Patient's Name

NORTHWEST SPEECH AND HEARING CENTER
880 West Central Road
Suite 4300
Arlington Heights, IL 60005
Telephone (847)392-2250
Fax (847)392-2270

TO:

_____
Name of Facility

_____
Address

_____
City, State, Zip Code

_____
Fax/Phone Number

_____
E-Mail Address

I hereby release Northwest Speech and Hearing Center, Ltd., from all liability and all claims of any nature whatsoever pertaining to disclosure of this information.

_____ _____
Patient's Signature Date

_____
Date of Birth

If not signed by Patient, state relationship:_____