RELEASE OF INFORMATION

CONSENT TO RELEASE INFORMATION

I, _____, hereby give my permission for Columbus Speech and Hearing Center to release my records and or any information which they deem relevant to the following agency:

_____

_____

_____
Signature Date

****

CONSENT FOR COLUMBUS SPEECH & HEARING CENTER TO RECEIVE INFORMATION

TO: _____ RE: _____
Patient

_____ DOB: _____

_____

DATE: _____

You are hereby authorized to release any requested information on my behalf to:

Columbus Speech & Hearing Center
2424 Double Churches Road
Columbus, Georgia 31909
Phone: 706-324-6112
FAX: 706-596-8259

Thank you!

_____
Patient Signature

_____
Parent/Guardian Signature Date

_____
Witness