Hear 4 KiDz

PATIENT ______________________________

Print patients name

CONSENT FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize Hear 4 Kidz, Inc. to issue a copy of my audiogram and related hearing healthcare records to other healthcare providers when it is needed to facilitate the care of the patient.

CONSENT FOR RELEASE OF INFORMATION

I authorize Hear 4 Kidz, Inc. to give any medical information about the patient's treatment to any representative of the Patient's insurance company. I agree that my consent will continue until all bills for the treatment provided to the Patient have been paid and a review of such records is completed.

PAYMENT AGREEMENT

"I agree to pay Hear 4 Kidz, Inc. any and all charges incurred by visits and services rendered which are not covered by my insurance company."

______________________________ ______________________________

Name Relationship to the patient

____

Signature

______________________________ ______________________________

Witness (print full name) Signature