Suncoast Audiology, LLC

Protected Health Information Release Form:

Patient Name: _____ Date: _____

1) Concerning matters of my heath, I give permission for Dr. Dyson or a member of her staff to speak with:

Name of person: _____

Relationship to patient: _____

Name of person: _____

Relationship to patient: _____

Name of person: _____

Relationship to patient: _____

Name of person: _____

Relationship to patient: _____

2) I request that use and disclosure of the above described information be restricted in the following manner: (description of restriction)

_____

_____

3) I request that my protected health information not be disclosed to the following individuals or entities: (list individuals or entities to which information should not be disclosed)

_____

_____

Signature of patient: _____ Date: _____

Witness: _____ Date: _____