HEARING ASSOCIATES

Gabriela Perez-Saenz, Au.D. • Bruce Schachterle, Au.D.
Michael Iliff, Au.D. • John Molina, Au.D.
Doctors of Audiology

RELEASE OF INFORMATION

Patient: Name:______________________________

Address:______________________________

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Agency: Name:______________________________

Address:______________________________

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Fax:______________________________

Patient Signature______________________ Witness Signature ______________________

I authorize release of the following information to:

Hearing Associates
1550 S Potomac St, #305 • Aurora, CO 80012
Phone: (303) 369-1096
Fax: (303) 369-1097

Audiograms______________

Reports______________

Other______________