1411 Secret Ravine Parkway, Suite 120
Roseville, CA 95661

INFORMATION EXCHANGE AND RELEASE OF INFORMATION FORM

The purpose of this form is to facilitate communication among your child's primary physician, Otolaryngologist, school personnel and other private therapist.

Authorization: I hereby authorize Roseville Diagnostic Hearing Center, Inc. to release/obtain/both information to/from the following organization listed below. All information shared is pertinent to the continuity of medical care and treatment for the patient listed below:

Child's Name: ______________________________ **DOB**:______________________________

Primary Care Physician: ____

Address:____

Telephone Number:______________________________ Fax Number: ______________________

Otolaryngologist (ENT):____

Address:____

Telephone Number:______________________________ Fax Number: ______________________

Speech Therapist: ____

Address:____

Telephone Number:______________________________ Fax Number: ______________________

Other:____

Address:____

Telephone Number:______________________________ Fax Number: ______________________

I understand that this consent shall expire 12 months from the signed date or until I revoke the consent at any time.

I understand that a copy of this consent is acceptable as the original one.

______________________________________ ______________________

Signature of Parent or Legal Guardian **Date**