Pacific Coast Hearing Care

Medical Record Release Form

Patient Name _____ F / M D.O.B. _____

Last First M.I.

Requests the release of medical records relevant to audiology diagnosis and treatment.

Requests that the medical records be transferred

To:	**From**: Pacific Coast Hearing Care
	414 N Camden Dr. Ste 975
	Beverly Hills, CA 90210
Phone:	**Phone:** 310-247-0344
Fax:	**Fax:**
Email:	**Email:**

Records being requested:

- ☐ Previous audiological test results
- ☐ Hearing aid information
- ☐ Reports

Signature of Patient or Guardian _____ **Date** _____