Authorization Release Form

I, _____, do hereby authorize The Hearing Aid
(Patient Print Name)
Company of Texas permission to forward a copy of my hearing evaluation results to my Primary Care Physician.

Primar Care Physician Name: _____
(Print Name)

_____ _____
Patient Signature Date

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Corpus Christi, TX 78412
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361.814.3487

13310 Leopard St., Ste 22
Corpus Christi, TX 78410
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Beeville, TX 78102
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La Feria, TX 78559
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