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RELEASE OF INFORMATION

Please print below any persons you wish Adept Audiology to release your health information to:

1. **Primary Care/Pediatrician** _____

2. _____

Relationship to Pt _____

3. _____

Relationship to Pt _____

4. _____

Relationship to Pt _____

By signing below, I hereby acknowledge that I have read and fully understand the terms and conditions of the Notice of Privacy Practices provided by Adept Audiology, LLC and have had the opportunity to ask questions about the use and disclosure of my health information.

Patient Signature

Effective Date

Print Patient Name