Advanced Hearing Center

Consents and Releases

FOR MINOR PATIENTS, IF APPLICABLE:

I give my permission for Advanced Hearing Center to evaluate and treat my minor son or daughter, ___________________________, in your office without my presence. I understand that any procedures, such as cerumen removal, will require my presence. I also understand that payment will still be due at the time services are rendered.

I hereby give my permission to allow ___________________________ to act on my behalf regarding the medical care of my minor son or daughter.

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Parent or Guardian Signature

Should you choose to allow your parent or spouse or someone else to have access to your medical records and discuss medical conditions/history, please sign below.

I authorize, _____________________________, who is my **PARENT/SPOUSE/OTHER** _________________ to have access to my medical records. **(circle one)**

Signature: ______________________________ Date: ________________

Marilyn M. Hinrichs, Au.D., CCC-A
17390 Preston Road, Suite 320, Dallas, TX 75252 Phone (972) 733-3344 Fax (972) 733-3852
www.advancedhearingcenter.com