Hear in ARIZONA

Shared Information Consent Form

Patient Name: _____

Email Address: _____

Emergency Contact:

Name: _____

Phone Number: _____

Relationship to Patient: _____

Individuals you would like us to share your information with:

Name: _____

Phone Number: _____

Relationship to Patient: _____

Name: _____

Phone Number: _____

Relationship to Patient: _____

Name: _____

Phone Number: _____

Relationship to Patient: _____

Name: _____

Phone Number: _____

Relationship to Patient: _____

I consent to Hear in Arizona sharing information regarding my diagnosis and/or treatment plan with any of the above-listed individuals.

_____ _____

Signed Date

Megan Booth, Au.D. | Doctor of Audiology
PH: 928-284-2116 | FAX: 928-284-2691 | 6446 State Route 179, Suite 209, Sedona, AZ 86351 | hearinarizona.com