Windsor Audiology
Hearing and Tinnitus Clinic

Leann Johnson, Au.D.
Board Certified Doctor of Audiology
Your Hearing Healthcare Journey
Begins Here

PROTECTED HEALTH INFORMATION RELEASE

Patient's Name: _____ Date of Birth: _____

Individual Persons

I give Windsor Audiology permission to release my health care information to the following individuals. This line may be left blank if you choose.

1) _____ 3) _____

2) _____ 4) _____

Physician's Offices

◯ I give Windsor Audiology permission to release information regarding my hearing health to my Physician's office listed_____

Detailed Voicemail

◯ Windsor Audiology has permission to leave a detailed voicemail regarding my hearing health care including but not limited to; Appointments, repairs, test results, and cost.

◯ Windsor Audiology DOES NOT have permission to leave a detailed voicemail regarding my hear health care.

Electronic Communications ie: Email or Text

◯ I allow Windsor Audiology to communicate my personal health care information to me through unsecured forms electronic communications.

◯ I DO NOT allow Windsor Audiology to send my personal health care information to me through electronic communications

Marketing and Newsletters

◯ I would like to receive Quarterly Hearing Healthcare E-Newsletters and other special offers at my email on file.

◯ I DO NOT want to receive Quarterly Hearing Healthcare E-Newsletters and other special offers at my email on file.

I understand that this for will remain valid until I have given written request for Windsor Audiology to change or cancel any and/or all parts of the release.

Patient Signature_____Date Signed_____