



**AUDIOGRAM AND RELATED RECORD RELEASE
To Link Audiology**

Date: _____

Patient Name: _____ DOB: _____

Address: _____

I authorize _____ to issue a copy of my audiogram and related hearing healthcare information records associated with the above patient to:

Link Audiology, LLC
9576 Ridgetop Blvd., Suite #103
Silverdale, WA 98383

Phone: 360-551-4800
Fax: **360-551-4801**

Attn: _____

Signature

Date

Printed Name

Relationship to patient (if applicable)