



Round Rock Sertoma Club
PO Box 412
Round Rock, Texas 78680

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____, do hereby consent to and authorize
(Name of Client Patient)

(Name of Attending Physician, Audiologist)

(Address)

to obtain from/release to:

(Name of Sertoma Representative)

(Round Rock Sertoma Club)

information pertaining to my identity, diagnosis, prognosis, and/or treatment plan.

This information is needed for the following purposes:

- To provide ongoing assessment and treatment plan.
- To obtain possible financial assistance benefits from Sertoma.
- To coordinate treatment with my family/concerned persons.
- Other: _____

I understand that by law, I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purposes specified above. This authorization will have a duration of consent no longer than one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on my consent.

I understand that I am entitled to a copy of this document in its completed form.

(Signature of Patient or Parent of Minor Child)

(Date)

(Signature of Witness)

(Date)