HEARING TEST CONSENT FORM

Patient Information			
First Name	**Last Name**	**Date of Birth**	**Gender**
Street Address	**City**	**State**	**Zip Code**
Phone Number	**Email Address**	**Contact Preference**	

Primary Care Physician		
Full Name/Practice	**Address**	**Phone Number**

I, the undersigned, consent to undergo a hearing test screening to evaluate my hearing health. I understand that the results of this test will be used for diagnostic and treatment purposes. I acknowledge that I have been provided with information about the procedure and its potential risks and benefits.

Signature Date: **Signature:**