Authorization for Community Audiology Services, LLC (CAS) to Release Medical Records

Date: _____/_____/_____

Patient:
(Please print.)

Name: _____ Date of Birth: _____/_____/_____

Address: _____Apt./Suite_____City_____Zip_____

Home Telephone:_____Cellular Telephone:_____

I authorize:

Community Audiology Services, LLC
11120 New Hampshire Avenue, Suite 504
Silver Spring, MD 20904
Phone: (301) 593-3200
Fax: (301) 593-3900
E-mail: Communityaudiology@gmail.com

to release all medical records for _____ including audiograms,
(Patient's Name)

medical clearance forms for hearing aid use, and other pertinent information to:

_____at

Telephone: _____FAX: _____.

_____
Signature of Authorizing Patient, Guardian, or Personal Representative Date