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

Date: _____/_____/_____

Patient:
(Please print.)

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

Address: _____Apt./Suite_____City_____State_____

Home Telephone:_____Cellular Telephone:_____

I authorize:

_____ at

Phone: _____FAX: _____

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

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

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

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Signature of Authorizing Patient, Guardian, or Personal Representative Date