COMMUNITY AUDIOLOGY SERVICES

CAS D2 12/12/15

Patient's Request for Audiogram Record(s)*

Date: _____/_____/_____

Requesting Patient:
(Please print.)

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

Address: _____Apt./Suite_____City_____Zip_____

Home Telephone:_____Cellular Telephone:_____

My signature below indicates that I have requested a copy of my own audiogram record(s) from:

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

I authorize CAS to send a copy of my own audiogram record(s) to me via:

- Email:_____(email address)
- FAX: _____(FAX number)
- Address above

_____

Signature of Requesting/Authorizing Patient **Date**

**Requesting patient should complete and return this form to Community Audiology Services, LLC.*