HearingDoctors
Audiology & Balance Experts

Release of Patient Information

Patient Name: _____ **Date of Birth (MM/DD/YY):** _____

Address: _____

City: _____ **State:** _____

Email: _____ **Phone:** _____

I authorize _____
(Physician / Medical Group)

Address: _____

Phone: _____

to disclose my health information to Hearing Doctors. Please send the information listed below to:

☐ **McLean, VA**
1320 Old Chain Bridge Road,
Suite 185
McLean, VA 22101
Phone: (703) 942-8110

☐ **Cascades, VA**
46045 Palisade Parkway,
Suite 200
Potomac Falls, VA 20165
Phone: (571) 210-6781

☐ **Fairfax, VA**
3930 Pender Drive
Suite 140
Fairfax, VA 22030
Phone: (571) 432-0640

☐ **Rockville, MD**
133 Rollins Avenue, Suite 2
Rockville, MD 20852
Phone: (301) 468-7670

☐ **Falls Church, VA**
300 North Washington St,
Suite 102-A
Falls Church, VA 22046
Phone: (703) 237-0163

Information to be disclosed:

1. _____
2. _____
3. _____
4. _____
5 _____

Patient Signature: _____ Date (MM/DD/YY): _____