Release of Patient Information

Patient Name: _____ **Date of Birth (M/D/Y):** _____

Address: _____ **City:** _____ **State:**_____

Email: _____ **Phone:** _(_____)_____—_____

I authorize _____

Physician / Medical Group

Address: _____ Phone: _(_____)_____—_____

to disclose my health information to Ascent Audiology & Hearing. Please send the information listed below to:

☐ Ascent Audiology & Hearing
1320 Old Chain Bridge Road,
Suite 185
McLean, VA 22101
Phone: (703) 942-8110
Fax: (703) 942-8042

☐ Ascent Audiology & Hearing
46400 Benedict Dr.,
Suite #0007
Sterling, VA 20164
Phone: (703) 595-4476
Fax: (703) 522-4687

☐ Ascent Audiology & Hearing
1715 N. George Mason Dr.,
Suite #203
Arlington, VA 22205
Phone: (703) 595-2176
Fax: (703) 522-4687

☐ Ascent Audiology & Hearing
Lansdowne Woods Clubhouse
19375 Magnolia Grove Sq.
Lansdowne, VA 20176
Phone: (703) 992-8814
Fax: (703) 942-8042

☐ Ascent Audiology & Hearing
19415 Deerfield Avenue,
Suite 301-B
Lansdowne, VA 20176
Phone: (703) 723-9672
Fax: (703) 724-0127

☐ Ascent Audiology & Hearing
133 Rollins Avenue,
Suite 2
Rockville, MD 20852
Phone: (301) 468-7670
Fax: (301) 468-7620

Information to be disclosed:

1) _____

2) _____

3) _____

4) _____

5) _____

Patient Signature: _____ Date (M/D/Y): _____