HearingDoctors
★★★★★ 5-Star Award-Winning Audiology

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:

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

☐ Hearing Doctors
3930 Pender Drive
Suite 140
Fairfax, VA 22030
Phone: (571) 432-0640
Fax: (571) 407-5266

☐ Hearing Doctors
300 North Washington St,
Suite 102-A
Falls Church, VA 22046
Phone: (703) 237-0163
Fax: (703) 237-2716

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

☐ Hearing Doctors
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 (MM/DD/YY): _____