Drs. Wayne and Fred Shaia
10200 Three Chopt Rd
Henrico, VA 23233
Phone:804-288-3277
Fax: 804-282-1043

Medical Release of Information

Patient Name: _____

Address: _____

SSN#: _____ Birth Date: _____

Please check appropriate box

[ ] Above listed patient is giving the authorization for the Balance and Ear Center to send their Medical Records to:

Business Name: _____

Attn: _____

Address_____

City _____St _____ Zip_____

Phone _____ Fax _____

[ ] Above listed patient is giving the authorization for the facility listed below to send their Medical Records to the Balance and Ear Center, Inc.

Facility Name: _____

Dr. _____

Fax #: _____ Phone #: _____

Please fax the following medical records to Dr. Shaia at 804-282-1043

- ☐ Hearing Test
- ☐ CT, MRI, Report
- ☐ Sleep Study
- ☐ CXR, EKG, Cardiac Clearance
- ☐ Other: _____
- ☐ Labs
- ☐ Office Notes
- ☐ All Records
- ☐ Pathology Report

[ ] Above listed patient is giving permission for:

_____, who is my _____ to be able to speak with Fred T. Shaia, MD, or Wayne T. Shaia, MD about my medical condition and treatment.

_____ Date: _____
Patient's Signature

_____ Date: _____
Witness Signature