Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ **Date of Birth**: _____

The information you may release subject to this signed release form is as follows:

☐ Complete Records	☐ History & Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Reports	☐ Medication Record	☐ Other (please specify below)

INFORMATION RELEASED BY:

DOCTOR'S NAME: _____ **Address:** _____

City: _____ **State:** _____ **ZIP:** _____

Phone Number: _____ **FAX Number:** _____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

COMPASSIONATE CARE CONSULTANTS
116 E. Pittsburgh St., Suite 100A, Greensburg, PA 15601

FAX: (443) 345-3069
PHONE: (484) 320-6550

PLEASE FAX RECORDS BACK TO:

(443) 345-3069

Signature:

_____ _____
Patient Name **Signature of Patient**

_____
Date Signed

_____ _____
Patient Phone Number **Patient Email Address**