

## 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:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Complete Records  | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes               |
| <input type="checkbox"/> Care Plan         | <input type="checkbox"/> Lab Reports        | <input type="checkbox"/> Radiology Reports            |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Treatment Record   | <input type="checkbox"/> Operative Reports            |
| <input type="checkbox"/> Hospital Reports  | <input type="checkbox"/> Medication Record  | <input type="checkbox"/> 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