

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