

**Medical Records Release and Authorization for
Use of Disclosure of Protected Health Information**

Please complete the following information:

Patient's name: _____ Date of birth: ___/___/_____

Address: _____

Phone: (____) ____ - _____ Last four of SSN: _____

I authorize the custodian of records of (provider/entity): _____

Address: _____

Phone: (____) ____ - _____ Fax: (____) ____ - _____

To disclose/release the following information:

- | | |
|--|--|
| <input type="checkbox"/> All records | <input type="checkbox"/> Radiology reports |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Billing records |
| <input type="checkbox"/> Lab reports | <input type="checkbox"/> Pharmacy/prescription reports |
| <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Other: _____ |

Please send the records requested above to:

Antietam Oncology & Hematology Group
1130 Opal Court
Hagerstown, MD 21740
Phone: (301) 797-8279
Fax: (301) 797-8504

Patient's signature: _____ Date: ___/___/_____