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

Please complete the following information:

Patient's name:_____ Date o birth: ___/____/_____

Address: _____

_____

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

I authorize the custodian of records of:

Antietam Oncology & Hematology Group
1185 Imperial Dr. Suite 103
Hagerstown, MD 21740
Phone: (301) 797-8279
Fax: (301) 797-8504

To disclose/release the following information:

☐ All records ☐Radiology reports

☐ Office Notes ☐Billing records

☐ Lab reports ☐Pharmacy/prescription reports

☐ Pathology reports ☐Other:_____

Please send the records requested above to (provider/entity):_____

Address:_____

_____

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

Patient's signature: _____ D te: ____/____/_____