REQUEST FOR RELEASE OF MEDICAL RECORDS

From: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PLEASE INCLUDE THE FOLLOWING:

_____ HISTORY AND PHYSICAL

_____ DISCHARGE SUMMARY

_____ LAB/X-RAY REPORTS

_____ OTHER: _____

_____

_____

_____

_____ ALL MEDICAL RECORDS

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

Heartland Hematology & Oncology, PC
412 West 42nd Street
Kearney, NE 68845

PHONE: (308) 865-2303
FAX: (308) 865-2304

_____ _____
PATIENT PRINTED NAME DATE OF BIRTH

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

_____ _____
PATIENT SIGNATURE DATE

_____ _____
or AUTHORIZED REPRESENTATIVE SIGNATURE Reason