

MEDICAL RECORDS REQUEST
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I hereby authorize _____ to forward medical
(Name of physician, institution, or other health care provider)

records summary thereof on _____ to:
(Name of patient/resident)

(Name of Homes Plus Provider)

(Address)

(Telephone #)

SIGNED BY:

Resident or Resident's Agent

(Date)

(Print Name)

(Telephone #)

(If agent, relationship to resident)