MAPLE MEDICAL,™ LLP

Pulmonary, Critical Care, Internal Medicine, Endocrinology, Cardiology, Nephrology & Gastroenterology

RELEASE OF MEDICAL RECORDS
TO MAPLE MEDICAL, LLP

Patient Name: ____ **Phone Number:** ________________

Patient Address: _________________ **City:** _____________ **State & Zip Code:** ___________________

Social Security Number: ___________________________ **Date of Birth:** ___________________

SEND INFORMATION TO: MAPLE MEDICAL, LLP

Physician's Name: _____________________________ Attention: _________________________________

Street Address: _____________________ City: ___________________ State & Zip Code: ________

Please check one:

SEND COMPLETE MEDICAL RECORD: YES: ____________

SEND TREATMENT DATES, X-RAYS & IMAGES: FROM: ________________ **TO::** ______________

TO BE READ AND SIGNED BY THE PATIENT: ***I understand the following.***

- I hereby permit the use or disclosure of my protected health information (PHI) to the person (s) specified in this authorization.

Patient Signature: _____________________ **Date:** ____________

Patient Representative: _____________ **Relationship:** __________ **Date:** _____________