Medical Release Form

Dear Dr. _____ or Office Manager,

Your patient, _____, D.O.B. _____, S.S. # _____
(Print Patient Name) (Last 4 Digits)

Has chosen to apply for SOURCE; a long term Medical Waiver Program. The Patient will benefit from a CNA/Caregiver who will come to their home and assist them with their daily needs. In order for us to facilitate the process, please provide us with the following: a current copy of their H&P, recent medication list, diagnosis, and a copy of the two most recent office visits.

I, _____ consent to the release of information and/or disclosure to
(Print Patient Name)

Favored Healthcare Services and SOURCE, all or any part of my medical record by any physician, hospital, or other facility of which I have been a client. Disagreement is valid until client is discharged from Favored Healthcare Servies.

Signed,

_____ _____
(Patient Signature) (Date)

Thank you in advance for your cooperation.

_____
(Partner)

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