Osteopathic **H**ealthcare of **M**aine

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AUTHORIZATION FOR OHM TO OBTAIN CONFIDENTIAL MEDICAL RECORDS

I hereby authorize Osteopathic Healthcare of Maine to **obtain** records from:

Physician/Healthcare Provider_____

Address_____

_____

Phone_____ Fax_____

<u>This release is valid for this request only.</u>

Patient name (Print)_____ Date of Birth_____

Signature of Patient/Guardian_____ __Date_____

____X-Ray/MRI Time Frame: _____ to _____

____Labs only

____Other

____Office Notes Only

____Complete Record