Osteopathic Healthcare of Maine

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AUTHORIZATION FOR OHM TO OBTAIN CONFIDENTIAL MEDICAL RECORDS

I hereby authorize Osteopathic Hea	althcare of Maine to obtai	n records from:	
Physician/Healthcare Provider			
Address			
Phone			
<u>Thi</u>	s release is valid for this re	equest only.	
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			