



*Heart to Heart Hospice, Inc.*

CONSENT FOR RELEASE OF INFORMATION

I authorize \_\_\_\_\_ to release information or copies from my medical record. I understand that by giving my permission, I hereby release the above named facility/agency from all present or future liability.

Please release the information to:

HEART TO HEART HOSPICE, INC.

Attention: \_\_\_\_\_

PO BOX 875

BELMONT, MS 38827

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

SSN#: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Please release: Discharge Summary \_\_\_\_\_

History & Physical \_\_\_\_\_

Lab & X-Ray Reports \_\_\_\_\_

Diagnosis/ICD9 \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Clinician

\_\_\_\_\_  
Date



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