AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/MEDICAL INFORMATION

I hereby authorize HomeNurse, Inc. to receive information from the medical records of:

Patient:_____ SSN _____
First Last Name

Date of Birth:_____ Date (s) of Service: _____

Information Requested (to be completed by HomeNurse, Inc.):

_____

_____

_____

Requested by: HomeNurse, Inc. Phone: 770-227-5757 ext. 1266
678-562-9114 fax

Purpose or need for information: Will be used in the process of applying for the Medicaid programs of SOURCE, CCSP, NOW, and COMP.

_____ _____
Signature of Patient or Authorized Person Date

_____
Relationship if not Patient

_____ _____
Signature of Witness Date

Please send all information to: HomeNurse, Inc.
Referral Department
PO Box 637
Sunnyside, GA 30284

Or

Fax :(No Cover Sheet Needed) **678-562-9114**
Email: rdavis@homenurse.net