Hass Family Medicine | Cape Cod

COMMITTED TO PRIMARY CARE ON THE CAPE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name: _____

DOB: _____

I request and authorize _____

Phone: (_____) _____ FAX: (_____) _____

To release my medical records to:

Dr. Joel Hass
Hass Family Medicine Cape Cod, PLLC
P.O. Box 549
Barnstable, MA 02630
Ph: (508) 815-3030 Fax: (508) 290-0802

Please release the following health information: (*check one*)

☐ Last 2 years records, including Preventative care, Diagnostic testing, Labs, Medication and Problem List

☐ Specific information regarding the below dates and/or conditions only.

_____

In addition, I authorize the release of information related to: (*initial all that apply*)

☐ Mental Illness ☐ Drug and Alcohol Issues

☐ HIV and HIV Related Disease

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Patient Signature Date signed

Witness

THIS AUTORIZATION IS VALID FOR 90 DAYS FROM THE DATE OF SIGNATURE