

DIVERGENT ND

Authorization for Release of Medical Records

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

RECORDS REQUESTED FROM

Complete the provider or agency below. If unknown yet, leave blank and Divergent ND will help you complete it.

Hospice / Agency / Facility Name: _____

Provider Phone: _____ Fax: _____

PLEASE RELEASE THE FOLLOWING RECORDS

☐ Discharge Summary ☐ History & Physical (H/P) ☐ Medication List

☐ Lab / X-ray Reports ☐ Diagnosis / ICD-10 ☐ Therapy Notes

☐ Face-to-Face Documentation ☐ POLST / Advance Directive

Other: _____

RELEASE RECORDS TO

Divergent ND - Marcy Goma-Brewer, Community Liaison
Phone: 480.943.8663 | Email: marcy@getvictorycare.com

AUTHORIZATION

I hereby authorize the provider or agency named above to release copies of my medical records, or the records of the patient named above, to Divergent ND for the purpose of coordinating care and services. I understand that by giving my permission I release the disclosing provider from all present or future liability related to this disclosure. This authorization may be revoked in writing at any time.

Signature of Patient or Authorized Representative: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____