111 PARK AVENUE ▲ BALTIMORE, MARYLAND 21201 ▲ 4108375533 ▲ Fax: 4108378020

HEALTH CARE FOR THE HOMELESS

# REQUEST FOR MEDICAL RECORDS FROM ANOTHER FACILITY

Date: ____________________

To: ________________________________________
(Name of medical facility)

________________________________________
(Address)

________________________________________
(City / State / Zip Code)

I, ______________________________ (please print patient name), ____________________ (social security number), ______________ (date of birth)

hereby authorize and request you to release copies of all my medical care to:

**HEALTH CARE FOR THE HOMELESS**
**111 PARK AVE.**
**BALTIMORE, MD 21201**
**Phone: 410-837-5533**

**Please** include the following information:

- ❒ History and Physical
- ❒ Medical Progress Note
- ❒ Nursing Notes
- 0 Medication Sheet
- ❒ Labs / X-Rays / Consultations
- ❒ Mental Health Records
- ❒ Addictions Records
- ❒ Social Service Records
- ❒ Other: ________________________________________

Dates of Service from: ____________________ to ____________________

This authorization shall remain in effect until: ____________________

______________________________
Signature

______________________________
Witness