HERITAGE HEALTH
SERVICES

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of any and all medical records related to my medical condition and treatment including:

_____ Personal Care Screening Tool

_____ Medication List

_____ Diagnoses

_____ Records of treatment

Medical Provider Name:_____

Please send the above authorized information to:

Heritage Health Services, LLC
6634 Durand Ave
Racine, WI 53406
Telephone: 262-554-8800
Fax: 844-505-8800

My signature below indicates authorization to release all medical records requested.

A photocopy of this authorization shall have the same force and effect as an original. All prior authorizations are canceled.
I have executed this document on (date)_____. This authorization is valid for 2 years from the date of execution.

Name of Client (Print): _____

Signature of Client(Or Legal Guardian):_____

Date of Birth: _____ Telephone: _____