

BAXTER

FAMILY OF COMPANIES



MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date
of Birth: _____

***Patient is agreeing to have any and all medical records released to Baxter Family of DME's including: Protech Medical, American Mobility Products, Williams Medical, CareMed, Orthomotion, and Family Home Medical as related to the justification for recommended medical equipment or services. Please acknowledge this request by accepting the patient's signature below.**

Patient/Legal Representative Signature: _____

Date: _____

If signed by legal representative, provide name and relationship below:

Legal Representative Printed Name: _____

Relationship to Patient (parent, legal guardian, etc.): _____