Dr. Martha Cole

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print

Patient Name		Other Last Names
Date of birth	Phone Number	Email Address
Street Address		City, State, Zip code
Transfer of ca	are is required due to the closing of m	ny physician's office. Therefore, I hereby authorize
N	Morgan Records Management LLC, 1	59 Frontage Rd, Manchester, NH 03103,
on behalf of I following:	Dr. Martha Cole, 4701 Willard Ave. S	te. 215 Chevy Chase, MD 20815 to execute one of the
	one of the following delivery option HIPAA approved electronic transfer: I	s: List email you want chart sent to here:
	disc, in person: Once chart is process gan Records, 159 Frontage Road, Ma	sed, you will be called to schedule pick up time. Our address nchester, NH 03103.
	ailed: There will be a \$10 shipping ch you want disc mailed to here:	arge prior to mailing. We mail USPS Certified Return Receipt.
authorize you obtained fro	bove records. Any facsimile, copy, o u to forward my medical records. Thi	_, am the patient or legal guardian who has authorization to r photocopy of this release will be valid for 90 days and shall is form gives you permission to share my private information his facility can be legally released. Any records from other
•	CREDIT CARD – please use our on My Records CHECK - please mail your complet	cessing of the records. Payment Options: line form: MorganRM.Com-> Medical Records tab-> Request ed authorization form with an attached check or money ecords Management LLC, to 159 Frontage Rd, Manchester,
Patient or Le	gal Guardian Signature	Date

Your completed authorization form may be faxed to 603-509-3987, emailed to Medical@MorganRM.com, or mailed to Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103.