ALPHA HOME CARE SERVICES, LLC
1770 Indian trial Rd. Suite 360 Norcross, GA 30096
Phone: 470- 807- 9131 - Fax - 855-812-1458
Email: inbox@alphahcs.org

# MEDICAL RELEASE FORM

Dear Dr. _____ or Office Manager.
*(Print Doctor's Name)*

Address _____
*(Print Doctor's Address)*

Phone _____ Fax _____
*(Doctor's Phone #)* *(Doctor's Fax #)*

Your patient, _____,
*(Print Patient Name)*

Date of Birth (DOB) _____, SS# _____
*(Last-4-Digits Only)*

has chosen to apply for SOURCE, a long term Medicaid Waiver Program. The patient will benefit from having a CNA providing In-Home Assistance with Daily Living Activities. In order for us to facilitate the process, please provide us with a current copy of his/her H&P, recent medication list, diagnosis, and a copy of two most recent office visits record.

I, _____
*(Print Patient Name)*

give permission for _____
*(Print Doctor's Name)*

to fax a copy of my H&P, current medication list, diagnosis, and current medical records for the last two visits.

Signature _____ Date _____
*(Patient Signature)*

Thank you in advance for your cooperation.
**Alpha Home Care Services, LLC**

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Name of Requester