



**TRANSCEND
MEDICAL**

Going Beyond The Limits

www.transcendmedical.net

800-403-3740

Consent to Release Medical Records

I, _____, authorize the release of my medical records to Transcend Medical, so they will be able to obtain information needed to bill my insurance.

___ Oxygen Saturation/Blood Gas Reports

___ Certificate of Medical Necessity for _____

___ History and Physical

___ Discharge Summary

___ Physician Consults/Summary

___ CT Scan and Reading

___ Other _____

Signature _____

Date: _____

Printed Name _____

DOB: _____