AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, (Patient Name)_____ DOB: ____/____/____

SSN:_____-_____-_____

Hereby grant,

Doctor: _____

Address: _____

City, State, Zip: _____

Phone: (_____) _____-_____ **Fax: (_____) _____-_____**

Permission to release medical information to include *specifically*:

- ☐ **Lab Findings**
- ☐ **HIV/AIDS**
- ☐ **Progress Notes**
- ☐ **Evaluations / Assessments**
- ☐ **Testing Records**
- ☐ **Discharge Summary**
- ☐ **Social History**
- ☐ **Alcohol/Drug Abuse Treatment Information**
- ☐ **Treatment Plan**
- ☐ **Exchange information while active, not to exceed one year**
- ☐ **Consultations**
- ☐ **Other:** _____

The above information is to be released to:

Doctor: WOMENS PELVIC SPECIALTY CARE, PC

Address: 4705 MONTGOMERY BLVD, NE STE 201

City, State, Zip: ALBUQUERQUE, NM 87109

Phone: (505) 888-0443 **Fax:** (505) 888-1398

Patient's Signature: _____ **Date:** ____/____/____

Guardian's Signature: _____ **Date:** ____/____/____

Staff Signature: _____ **Date:** ____/____/____

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (420FR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as other permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.