

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

SSN: _____ - _____ - _____

Hereby grant,

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

Permission to release medical information to include *specifically*:

- | | |
|--|--|
| <input type="checkbox"/> Lab Findings | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Evaluations / Assessments |
| <input type="checkbox"/> Testing Records | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Alcohol/Drug Abuse Treatment Information |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Exchange information while active, not to exceed one year |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Other: _____ |

The above information is to be released to:

Doctor or Self: _____

Address: _____

City, State, Zip: _____

Phone: () - _____

Fax: () - _____

We require a \$35 fee for all outgoing medical records which are in duplicate.

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.