

1268 E. 32nd Street Silver City, NM 88061

Email: contact@southwestboneandjoint.com

Authorization to Release Patient Medical Information

Patient Information

Account Number: _____

Patient Name (Please Print): _____

Former Name (If Any): _____

Social Security #: _____ Birthday: _____

Home Phone: _____ Cell Phone: _____

Information to be Released From

I hereby authorize: _____

To release the following medical information contained in the patient's medical record.

Information to be Released To

- 1. _____
- 2. _____
- 3. _____

Is this release of medical information for a Worker's Compensation Account? Yes No

Would you like your records to be:

- Picked up in our office
- Mailed, please list address _____
- Faxed, please list fax number _____
- Other, please identify _____

Type of Information to be Released

- 1. General release
Dates of Treatment: _____
 - Medical reports History and Physical Exam
 - EMG Reports Physical or Occupational Therapy
 - MRI Reports X-Ray / MRI CD
 - Other, please list _____

Purpose or Need for this Information

2. Information Protected by State / Federal Law

- Drug Abuse Diagnosis / Treatment Alcoholism Diagnosis / Treatment
- Mental Health Diagnosis / Treatment
- Sexually Transmitted Disease Diagnosis / Treatment or Counseling

Cost for Medical Records

For the first ten (10) pages there is no charge, for eleven (11) pages and more there is a ten (\$10.00) fee for medical records. For radiology and MRI images there is a five (\$5.00) fee for each CD.

Patient Authorization to Release Medical Information

Signature of Patient or Legally Responsible Party _____
Date

Relationship to Patient if not the Patient _____

*****Please allow 5-10 Business Days*****

Fee Paid: _____

This authorization is valid 90 days only and may be revoked in writing at any time prior to 90 days by notifying Southwest Bone and Joint Institute. (To be valid authorization must be signed and dated)