Phone: 575-534-1919 **SOUTHWEST BONE AND JOINT INSTITUTE, P.C.** Fax: 575-534-0135
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

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*******

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)