AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME ________________________________ TODAY'S DATE _________________________

DATE OF BIRTH ________________________________ DATE NEEDED __________________________

CONTACT NUMBER ____________________________

I hereby authorize:

Name: _________________________________

Address: ________________________________

City/State/Zip: ___________________________

Phone #: _________________________________ Fax #: ________________________

Copy and send my records to the following Physician/Medical Facility:

CASSIE HEALTH CENTER FOR WOMEN
Victor A. Nwachuku, MD/Michelle Diaz, MD/Gail Stamler, CNM
1618 E PINE STREET
SILVER CITY, NM 88061
PHONE: (575) 388-1561 FAX: (575) 388-9952

( ) All of my records.

( ) I am transferring care.

( ) Only the following records (provide specific dates)

____

____

____

Patient signature or representative of patient: _____________________________________Date____________

I would like my records:

( ) Faxed ( ) Mailed ( ) I will pick-up

CASSIE HEALTH CENTER