NEW MEXICO COLON & RECTAL SURGERY ASSOCIATES

3810 Masthead NE, Albuquerque NM, 87109 Phone 505-243-3514 Fax 243-3451

Authorization for Release of Medical Information

Patient Name _____ Social Security # (last 4 -digits only) _____

Date of Birth _____ Phone# _____

I hereby authorize _____ to release medical records concerning the following.

_____ All Records _____ History & Physical _____ Lab/Pathology Report

_____ Progress Notes _____ Radiology Report

Date(s) of service for which records are requested (if not all) _____

The above described records are to be released to:

_____ _____
Name Address

_____ _____
Phone # Fax #

For the Purpose of:

_____ Medical Appointment _____ Continuing Care _____ Insurance Information

_____ Attorney Use _____ Personal Use ____ Other_____

I hereby release the health care provider from all legal responsibility or liability that may arise from the authorization given above. A copy of the authorization shall serve the same purpose as the original. I understand I have the right to examine the information to be disclosed.

_____ or_____
Patient Signature Legal Representative

_____ _____
Date of Signature Relationship to Patient

This authorization shall expire in ONE YEAR from the date of signature unless otherwise specified.

_____
Witness Signature