5 Caliente Road #5
Santa Fe, NM 87508
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Authorization for Release of Medical Information

I authorize ______________________________ to release from the medical record of:

Full Name: ____
(please print)

Date of Birth: ________________ or Hearing Aid S/N: ___________________

Current Address: ____

_________________________________ Phone #: _________________

the following information (to include office notes): _________________________________

____

____

Send to: ____

Address: ____

Phone #: ____________________________ FAX #: _______________________________

I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to the disclosure of the above information to those persons or agencies named above. I hereby release _______________________________ from all legal responsibility or liability that may arise from the release of these medical records. I understand that I may revoke this authorization at any time (except retroactively) and this authorization will remain in effect until I offer a written request/authorization for it to be revoked.

Patient Signature: ______________________________________ Date: _______________________