Authorization for Release of Medical Records

Patient Name: ____ **DOB:** _____________

Address: ____ **Phone:** ______________

City, State, Zip: ____

I hereby authorize ____

____
(Address)

__________________________________ __________________________________
(Phone) **(Fax)**

to release information from my medical records. This disclosure may include any and all medical and/or billing records.

Please circle the type(s) of records you wish to have released:

Dates of Treatment: From: _____________ **to** _______________

Complete Records **Shot Records** **Billing Records** **Lab Reports**

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records. **Initials** ____________ **Date** _________

Please Release my medical records to:

Clovis Family Healthcare
2301 N MLK Jr. Blvd. Clovis, NM 88101
575-762-4455 575-762-8411
(Phone) (Fax)

I understand that I may cancel this authorization to release my medical records at any time by giving a written statement with my signature. I understand that the information to be released is not to be disclosed to any other individual or agency without my permission. This consent form will automatically expire 1(one) year from the date signed.

____ ____________________
Signature of Patient or Legal Representative **Date**