**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

*To Cassie Health Center*

Patient's Name:_____ Today's Date:_____

Date of Birth:_____ Date Needed:_____

Patient's Phone #_____

**I hereby authorize:**

Name:_____

Address:_____

City, State, Zip Code:_____

Phone#_____ Fax#_____

Release my records to:

**Cassie Health Center**
**1618 E. Pine Street**
**Silver City, NM 88061**
**Phone: (575)388-1561 Fax: (575) 388-9952**

*Michelle Diaz, MD ~ Anne Jones, CNM*

*Victor Nwachuku, MD*

( ) All of my records
( ) I am transferring care
( ) Only the following records (provide specific dates)

_____

_____

Patient's signature or representative of patient:_____

I would like my records:

( ) Faxed ( ) Mailed