

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

From Cassie Health Center-1280 E. 32nd Street Location

Patient's Name: _____

Today's Date: _____

Date of Birth: _____

Date Needed: _____

Patient's Phone # _____

I hereby authorize:
Cassie Health Center
1280 E. 32nd Street
Silver City, NM 88061

Phone: (575) 388-1889

Fax: (575) 388-9952

To copy and send my records to: *Myself* *Physician* *Medical Facility* *Other*

Name: _____

Address: _____

City, State, Zip Code: _____

Phone# _____

Fax# _____

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

Patient's signature or representative of patient: _____

I would like my records:

- () Faxed () Mailed () I will pick up when notified*

Request for medical records may take up to seven (7) business days to be processed.

*If records are not picked up within (1) one week of being notified, they will be destroyed. If requested again, \$10.00 fee will be charged.