AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

From *Cassie Health Center-****Pine Street Location***

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

Date of Birth:_____ Date Needed:_____

Patient's Phone #_____

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