AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

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

Victor Nwachuku, MD ~ Michelle Diaz, MD ~ Randi Murphy, DNP, FNP-C

Anne Jones, CNM ~ Aujenae Ore, CNM

( ) 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