Clayton Family Practice
315 North 3rd Ave
Clayton, NM 88415
Phone: 575-374-2273
Fax: 575-374-2498

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Pt Name: _____

Address: _____

Phone: _____ Date of Birth: _____

I authorize release of my medical record FROM:

Name of Doctor, Hospital, etc. _____

Address: _____

City/State/Zip Code: _____

PHONE: _____FAX: _____

Records release TO: _____

Address: _____

City/State/Zip: _____

PHONE: _____ FAX: _____

For the purpose of review/examination, I further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitation as indicated below:

_____ Entire Record

_____ Specific Information _____

****I give special permission to release any further information regarding: (Initial applicable lines below)**

_____ Substance Abuse **_____ Psychiatric/Mental Health Information**

_____ HIV Information **_____ Rape Information**

Patient's signature: _____ Date: _____

Guardian's signature: _____ Date: _____
(If patient is a minor or unable to sign)

Witness: _____ Date: _____