

Form 0802/IR: Incoming Records  
**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Patient Name: \_\_\_\_\_ Date Submitted: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Date Needed: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**I hereby authorize the following physician/medical facility:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_

to copy and send my medical records to:

**Silver Health CARE**  
**Dr** \_\_\_\_\_  
1600 East 32<sup>nd</sup> Street  
Silver City, NM 88061  
Phone #: 505-538-2981  
Fax #: 505-388-3373

- Please copy and send ALL of my medical records.
- Please include all medical records/reports which relate, in any way, to the Human Immune Deficiency Virus (HIV) infection/testing, and/or Acquired Immune Deficiency Syndrome (AIDS).
- Please copy and send only the following records (provide specific dates).

\_\_\_\_\_  
 Please send X-Ray(s) related to:

\_\_\_\_\_  
Signature of Patient:

\_\_\_\_\_  
Signature of Authorize Person:

\_\_\_\_\_  
(Person picking up records)

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_