

Form 0802/OR: Outgoing 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

Silver Health CARE
Dr. _____

1600 East 32nd Street
Silver City, NM 88061

to copy and send my medical records to the following physician/medical facility:

Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____
Fax #: _____

- 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 Authorized Person:

(Person picking up records)

Relationship: _____ Date: _____