Authorization For Use and Release of Health Records

Patient's Full Name _____ Date of Birth _____ Today's Date _____

RELEASE OF GENERAL HEALTH RECORDS

I, _____ ***, AUTHORIZE*** ***The Doc Spa***
Responsible Party's Name — Facility that Records are Being Requested From

TO RELEASE (DISCLOSE) THE FOLLOWING HEALTH RECORDS OF THE ABOVE NAMED PATIENT.

Type of Record(s)

☐ Vaccination Records ☐ Test Results ☐ Billing ☐ ALL HEATH RECORDS

Facility Releasing Records

Name of Facility: The Doc Spa Doctor _____

Service Dates: From _____ To _____

Address 6801 Jefferson Rd NE, Suite 350, Albuquerque, NM 87109

Phone Number 505-884-8900 Fax Number 1-888-699-4725

Facility Receiving Records

Name of Facility _____

Address _____

Phone Number _____ Fax Number _____

Records Released for the Following Purposes

☐ At the request of the individual

☐ Other _____

Type of Record Release

☐ Pick Up* ☐ Mail Out* ☐ Fax*

* A $25 flat fee will be charged if the records are not sent ***directly*** to a ***PHYSICIAN'S OFFICE***. A $15 fee will be charged for vaccination records.

I UNDERSTAND THAT THIS AUTHORIZATION TO RELEASE HEALTH RECORDS IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF PATIENT RECEIVING TREATMENT OR PAYMENT FOR SERVICES, EXCEPT AS PERMITTED BY LAW. I HAVE READ AND UNDERSTAND THIS AUTHORIZATION FORM. I AM THE PATIENT (OR LEGAL GUARDIAN) AND I LEGALLY AUTHORIZE TO EXECUTE THIS AUTHORIZATION AND ACCEPT THESE TERMS.

_____ _____

Patient or Authorized Representative/Relationship to Patient — Date