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 PO Box 91960 Albuquerque, NM 87199

______________________   Fax Number 1-888-699-4725

Phone Number 505-884-8900

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