



Authorization For Use and Release of Health Records

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

RELEASE OF GENERAL HEALTH RECORDS

I, _____, *Responsible Party's Name* **AUTHORIZE** _____ *Facility that Records are Being Requested From*
The Doc Spa
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 _____ *505-806-7183*

Phone Number _____ *505-884-8900*

Facility Receiving Records

Name of Facility _____

Address _____

Fax Number _____

Phone 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