REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Previous Name(s): _____ Phone number: _____

I hereby authorize and request that my medical records be released

FROM:

_____Alto Clinic
1035 Alto Street
Santa Fe, NM 87501
505-982-4425
505-982-1263 Fax

_____Southside Clinic
2145 Ceja Del Oro Grant Rd
Santa Fe, NM 87507
505-982-4425
505-982-1263 Fax

_____Dental Clinic
6401 Richards Ave.
Santa Fe, NM 87508
505-982-4425
505-983-1263 Fax

_____Health Care for the Homeless
1532 B Cerrillos Rd
Santa Fe, NM 87505
505-988-4425
505-983-1263 Fax

TO:

_____ SELF (Fees may Apply) **_____ DOCTORS OFFICE OR FACILITY** **_____ INSURANCE**

Name_____

Address_____

Phone # _____ Fax # _____

This authorization and request applies to:
(Please check which records you want sent from La Familia Health)

_____ **ALL** Healthcare Information (this includes everything listed below).
_____Healthcare information relating to the following treatment, condition or dates only:_____
_____ I authorize the release of my STD results, HIV/AIDS testing.
_____ I authorize the release of any records regarding drug, alcohol or mental health treatment.

****ALL FEDERAL HIPAA LAWS APPLY****

_____ _____

Patient/Legal Guardian Signature Date

Official Use Only - **FEES ARE IN ACCORDANCE WITH N.M. Admin.Code 8.370.6.10** ID Verified _____

___ $6.50: CD & non-paper format

____ Paper Chart Copy
____ 1 – 10 pages @ $2.00 per page
____ additional $0.20 per page

Total: _____

Method of Payment: _____ Received by:_____