Release of Information Authorization Form

Patient Name: _____ Date of Birth: _____ Last 4 of SSN: _____

I duly authorize:

Taos Medical Group
1399 Weimer Rd
Suite 200
Taos, NM 87571
Office: 575-758-2224
Fax: 575-758-4903

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Fax: _____

☐ To Release Information To:

☐ To Obtain Information From:

I authorize the release of the following health information: *Please check all that apply*

Note - Authorization for release of psychotherapy notes may NOT be combined with authorization for medical records. Please use a separate form for each of those releases.

☐ Entire Record

☐ Prescriptions ☐ Immunizations ☐ Lab Reports ☐ Imaging Reports

☐ Records from (date) _____ to (date) _____

This authorization will expire six months from the date it was signed unless another date is requested here: _____
I understand that I may revoke this authorization at any time in writing.

_____ _____
Signature of Individual or Personal Representative Date

Note: If signed by a Personal Representative, you must attach a copy of the basis of authority.

_____ ☐ Records Sent : _____
Staff Signature who witnessed signature above Date