SOUTHWEST
CENTER ON AGING

1106 CENTRE COURT | LAS CRUCES, NM 88011 | (575) 532-5455 | FAX (575) 532-5641

Patient Authorization for the Release of Medical Records

_____
Name (Please Print) Date of Birth

_____
Address City State Zip Ph #:

I hereby authorize:
_____
_____
_____

Release to:
_____
_____
_____

Records requested are as follows:
___ Lab Reports, X-Rays, EKG Reports
___ History and Physical, Echocardiograms
___ Nuclear/ Regular Stress Test
___ Holter Monitors
___ Cath/ PTCA/ Stent Reports
___ All Records
___Other: _____
_____

I specifically authorize the release of information relating to:
___ Substance abuse (including alcohol/drug abuse)
___ STD related information (HIV and AIDS related testing)
___ Mental health (including psychotherapy notes)

_____
Signature of patient or Legal Guardian

I understand that I have the right to revoke this authorization at anytime. I also understand that I must do so in writing and present my written revocation to Southwest Center on Aging at the above address. I understand that the revocation will not apply to my insurance company when insurers contest a claim under my policy.

_____ _____ _____
Signature of the Patient or Legally Authorized Representative Date Relationship to Patient

_____ _____
Witness- Printed Name and Signature Date