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

Release of Medical Information

I, ________________________ hereby give authority to _________________________________
(Patient's name) (Other than Physician)

__________________________, to have access to the medical information below, effective
(Relationship to patient)

____
Date

____ *Procedures*

____ *Medications*

____ *Appointment times and cancellations*

____ *Patient history*

____ *All medical information may be released to the above mentioned person(s).*

I understand that I may request to cancel this release of information in writing for whatever reason, at anytime and that information about me or anything pertaining to me will not be released to anyone but the person mention above. I also understand that Southwest Center on Aging cannot be held liable for any misuse of information obtained by the person mentioned above.

________________________________ _______________
Patient's Signature Date

________________________________ _______________
Witness Date