



NM Cardiac Care, P.C.

Providing Comprehensive Cardiovascular Care,
Interventional Cardiology
and Peripheral Vascular Intervention



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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

Received Records From: _____

Please send a copy of my records as indicated for date(s) of treatment to New Mexico Cardiac Care, P.C.

Operative Records: _____ Lab Reports: _____

H&P: _____ X-Ray Reports: _____

Discharge Summary: _____ CABS Report: _____

Other: _____

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems. This special consent will also apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.R.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith. This authorization expires ninety (90) days from the date of signature.

Signature of Patient or Authorized Representative

Date: _____

Witness

Date: _____

Permission to FAX records for medical emergency? Yes No