Release of Medical Records

Santa Fe Hand Therapy, LLC
2009 Botulph Road, Suite 200
Santa Fe, NM 87505

Patient's full Name: _____

Date of birth: _____ SSN: _____-_____-_____

I, the undersigned, hereby authorize:

Name of Patient, Facility and/or Physician: _____

Address: _____

City:_____ State:_____ Zip:_____

to release (disclose) the following health records of the above named patient:

[ ] Any and All Medical Records & Medical Bills (paid or unpaid)

[ ] Any and All Records from other Facilities/Providers

[ ] Other

Information may be released to:

Name: _____

Address: _____

City: _____ **State :**_____ **Zip:** _____

- I understand that signing this authorization is not a condition of patient receiving treatment or payment of services, except as permitted by Law.
- I understand that a signed photocopy or facsimile of this authorization is to be considered as valid as the original.
- I understand that the information obtained pursuant to this authorization may be subject to re-disclosure.
- I understand that there is a **$25.00** charge for any and all medical records.
- **I have read and understand this authorization form. I am the Patient or I am Legally authorized as the Patient's Representative to execute this authorization and accept these terms.**

Patient Signature_____ Date_____

Name of Legal Representative_____

Signature of Legal Representative_____