Kidney Specialists of New Mexico, P.C.

MEDICAL RECORDS RELEASE FORM

Patient Name:__________________________ Date of Birth: _______________

Patient authorizes*:* ____

To disclose medical records to: ______________________________________
Office/Provider Name

____
Address

____
Phone

____
Email

Delivery option: ☐ fax ☐ pick up (please fill below)

I hereby authorize ______________________________ to pick up my medical records.

Only information from the past five years will be disclosed unless otherwise requested

If you want the release of other information then please mark below:

☐ Note/Treatment Plan
☐ Radiology Films/Images
☐ All Billing Records
☐ Other :____

I do not want the following information disclosed: ______________________________

____

This Authorization is good for one year from signature date unless otherwise requested

Signature of Patient / Legal Representative:

____ **Date:** ___________________

Signature of Witness:

____ **Date:** ___________________

By signing, I understand that the information released by this authorization, if re-disclosed by the recipient, is no longer protected by ____.

HIPAA – Form 3A

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