DE BACA FAMILY PRACTICE CLINIC
Your Patient Centered Medical Home proudly serving De Baca, Guadalupe and surrounding counties.

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Phone 575-355-2414 Fax 575-355-7894

MEDICAL INFORMATION RELEASE FORM

Name: _____ Date of Birth: ___/___/____

Release of Information

[ ] I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

[ ] I authorize the release of my complete health record with the exception of the following information:

- [ ] Mental health records
- [ ] Communicable diseases (including HIV and AIDS)
- [ ] Alcohol/drug abuse treatment
- [ ] Other (please specify): _____

I authorize the release of information to:

- [ ] Spouse_____
- [ ] Child(ren)_____
- [ ] Other _____
  _____
  _____

This authorization for release of information covers the period of healthcare from:

- [ ] _____ to _____

OR

- [ ] all past, present, and future periods.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/____