4600 Jefferson # D
ALBUQUERQUE, NM 87109
phone 505-884-4406
fax 505-884-1671

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Patients Name:_____ Date of Birth: _____
AKA/ Previous Name: _____ Social Security #: _____

I request and authorize:

SANDIA NEUROLOGY
4600 Jefferson Lane Suite D
ALBUQUERQUE, NM 87109
phone 505-884-4406
fax 505-884-1671

To release healthcare information of the patient named above to:
(name of medical or other facility) _____

_____
(City) (State) (Zip code)

This request and authorization applies to:

☐ Most recent evaluation summarizing care

☐ Healthcare information relation to the following treatment, condition, or dates: _____

_____

Patient Signature:_____ Date Signed_____
(Or Authorized Patient Representative and Title)

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

ALL FEDERAL HIPPA LAWS APPLY