**SANDIA NEUROLOGY**
**4600 Jefferson Lane NE SUITE 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
(name of medical or other facility) _____

_____
(City) (State) (Zip code)

To release healthcare information of the patient named above to:

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

This request and authorization applies to:

☐ Radiology Records

☐ Lab Reports

☐ 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**