FOUR CORNERS
SPINE AND PAIN

2500 Farmington Ave., Farmington, NM 87401
PHONE: (505)326-PAIN (7246)
FAX: (505)592-0063

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name (Include Previous Names): _____

DOB: _____ SS#: _____

Address (Mailing): _____ City/State/Zip: _____

Address (Physical): _____ City/State/Zip: _____

TO BE RELEASED TO (Where information will be sent)

Four Corners Spine and Pain · 2500 Farmington Ave. · Farmington, NM 87401

Phone: 505-326-7246 Fax: 505-592-0063

PROVIDER RELEASING INFORMATION

Name/Clinic: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

INFORMATION REQUESTED

Progress Notes From: _____ To: _____

Copies of Imaging: From: _____ To: _____

Other: _____

By putting a check below and signing the appropriate area in the box, I authorize the release of information protected by state and federal law.

_____ Mental Health (Includes psychological testing)

_____ Substance Abuse (Alcohol/Drug)

_____ Acquired immune deficiency syndrome (AIDS), Human immunodeficiency virus (HIV) infection

Authorized Signature: _____ Date: _____

I hereby authorize the release of these medical records and reports regarding any examinations, treatments, including but not limited to history, diagnosis, objective findings, diagnostic reports, and prognosis. I understand that the release is valid up to one year from the date it is signed and I may revoke this authorization at any time by submitting the revocations in writing to Four Corners Spine and Pain Compliance Officer and delivered by certified mail.

Information that is disclosed may be re-disclosed by the recipient of the information and may not be protected by the federal privacy standards.

Signature of Patient or Legal Representative: _____ Date: _____

Relationship to Patient if not signed by Patient: _____ Witness: _____