

RELEASE OF MEDICAL INFORMATION HIPAA AUTHORIZATION FORM

If a patient is a minor or dependent, all parents or legal guardians must be listed below.

Should it become necessary, New Mexico Clinical Research & Osteoporosis Center, Inc, physicians and medical staff have my permission to discuss my health information, including test results, with the individuals listed below.

The people that are listed below are also authorized for the above statement regarding appointments, billing and prescriptions. I understand that if I need to change this information, it is my responsibility to request it in writing.

Name: _____ Relationship: _____

Phone No. _____ () Home () Work () Cell

Name: _____ Relationship: _____

Phone No. _____ () Home () Work () Cell

Name: _____ Relationship: _____

Phone No. _____ () Home () Work () Cell

Name: _____ Relationship: _____

Phone No. _____ () Home () Work () Cell

Printed Name: _____

Signature: _____ Date: _____