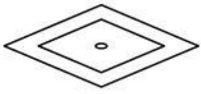


Southwest Obstetrics and Gynecology

Medical Records-Request

Patient Name: ______________________________ Date: ____________________

By signing this form I am allowing **Southwest OB/GYN, LLC** to release a complete copy of my medical information without restriction to the person or facility listed below:

____
(Name of Person and/or Institution to receive information)

____
(Complete mailing address)

____
(City, State, Zip Code) (Phone/Fax Numbers)

Patient DOB: ______________________________

Patient SS#: ______________________________

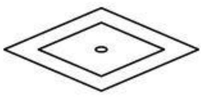
Patient Last seen: ______________________________

Patient Address: ______________________________

____

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to the Director of Health Information, **Southwest OB/GYN, 634 West Pinon St., Farmington, NM 87401**. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Southwest OB/GYN, LLC. at the above address. I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release: Substance Abuse, Mental Health, HIV-related information, and Genetic tests/information.

Signature: ____________________________________ Date: ____________________



Southwest Obstetrics and Gynecology

Southwest OB/GYN Questionnaire

Please fill out the short questionnaire below. We would appreciate your feedback good or bad. It is our goal to provide you with excellent service. If there is anything you were dissatisfied with during your visit or any aspect of your care we would appreciate your feedback in an attempt to improve service. (Please add pages if the space below is inadequate). **Return by Fax or Mail.**

1. Were you greeted courteously upon arrival to our office?

   ____
   ____
   ____
   ____

2. Did you have a pleasant interaction with your medical assistant (person performing your vital signs and/or bloodwork)?

   ____
   ____
   ____
   ____

3. Did you feel as though you were given an adequate amount of time with your physician and that your questions were answered to your satisfaction?

   ____
   ____
   ____
   ____

4. Is there any part of your experience during your visit that made you feel uncomfortable or that you would like to have handled in a different way?

   ____
   ____
   ____
   ____

Departing Patients

We are sorry to have you leave the care of our office. Please give use some feedback as to the reason for your departure from our office. Your comments are greatly appreciated.

____

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634 West Pinon Street, Farmington, New Mexico 87401
Telephone: (505) 325-4898, Fax: (505) 325-7898

www.Southwest-OBGYN.net