REQUEST FOR MEDICAL RECORDS

To: _____ **Date: _____**

By signing this form, I authorize release of my medical records to the office of:

Mark A. Fisher, MD
Southwest Obstetrics and Gynecology
634 West Pinon Street
Farmington, New Mexico 87401

Information Covered by this authorization:

All Medical Records, Mental Health/Psychiatric Records, Substance Abuse Records, Diagnostic Imaging Reports, Lab/Test Results, Medication List, and any other pertinent health related information

Purpose of Disclosure

Continuity of Care

Right to Terminate or Revoke Authorization

One may revoke or terminate this authorization by submitting a written revocation to:
Southwest OB/GYN, LLC.

Expiration Date of Authorization

This authorization is valid for 2 years from the above date or _____.

Patient Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date of Birth: _____

Last seen in what year: _____

Patient Signature: _____