AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Name	
Mailing Address	Telephone Number
City State Zip Code	DOB

I AUTHORIZE:

Name: **Bloom and Grow Pediatrics**
Mailing Address: PO Box 1902 Cloudcroft, NM 88317
Phone: 575-682-2002 **Fax: 575-682-2003**

To: ___ RELEASE MY RECORDS TO ___RELEASE MY RECORDS FROM

Name: _____
Mailing Address:_____
_____
Phone: _____
Fax: _____
Relationship:

The purpose of the authorization is:

___ Changing Medical Providers ___Legal Action ___Further Medical Care ___Personal

I authorize the release of the following information:

___Entire Record ___Immunizations ___Growth Charts ___Hospital Discharge Summary
___Labs ___Imaging

Records from (date) _____ to (date) _____
Records related to the following specific condition(s), test(s) or treatments(s):
_____

Other:
_____
_____

This authorization shall expire (date or event): .

I understand that if I do not specify an expiration date, this authorization will expire six months from the date on which it was signed.

I understand that I may revoke this authorization at any time in writing.

_____ _____

Signature of Individual or Personal Representative Authorized by Law Date

If signed by Personal Representative, basis of authority: _____

Bloom and Grow Use only Date(s) Requested: _____Date Received:_____