Southwest Women's Oncology, Inc.
5700 Harper Dr. NE, Suite 410
Albuquerque, NM 87109

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name_______________________________________ Date of Birth__________________________

I hereby authorize and request you to release health information from

____________________ to _____________________.

The information you may request is subject to this signed release form. Please check the applicable box below.

______**Any and all records, including records from providers outside Southwest Women's Oncology**

______**Any and all records created by or limited to Southwest Women's Oncology**

______ Other (Specify)____

Information to be released from:

Name: _______________________________ Address: ____

City: ___________________________ State: ____________ Zip Code: ____________________

Information to be released to:

Name: _______________________________ Adress: ____

City: ________________________________ State: ________ Zip Code: __________________________

This authorization for release of medical information is effective for one year. If additional information is needed after the expiration date of this authorization, an additional authorization will be required.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

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I understand that in the event Southwest Women's Oncology has disclosed information pursuant to this request prior to a subsequent revocation of the authorization by me, Southwest Women's Oncology, Inc. will not be held responsible for such disclosure.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

The purpose/reason for this release of information is as follows:

Signature:

______________________________	______________________________
Patient Name:	Signature of Patient or Patient Representative
______________________________	______________________________
Patient Date of Birth / SSN	Printed Name of Patient or Patient Representative
______________________________	______________________________
Date	Description of Patient Representative's Authority