



Infusion Therapy Services
 Specialty Mobility Services
 Home Medical Equipment
 Respiratory Services
 Retail Store Front

MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Patient Information

Patient Name: _____ Patient DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Entity Authorized to Release Patient's Medical Records

Name of current or former medical equipment supplier: _____

Release of Medical Records Instructions

Release my medical records to HME Specialists:

Email: 5058886505@hmespecialists.com

Mail: 611 Osuna Road NE

Fax: (505) 888-6505

Albuquerque, NM 87113

Send the following Medical Records (e.g. current prescriptions, sleep studies, clinical progress notes, demographics, etc.)

Send Medical Records No Later Than: _____

Patient Signature

By signing, I authorize the release of relevant medical documentation, as listed in instructions, to HME Specialists.

Patient or Patient Legal Representative

Date

Printed Name / Relationship to Patient

611 Osuna Road NE
505•888•6500 Phone

Albuquerque, NM 87113
505•888•6505 Fax

www.HMESpecialists.com
866•690•6500 Toll Free