HME Specialists LLC

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