EASTERN NEW MEXICO
FOOT & ANKLE

MEDICAL RECORDS RELEASE

☐ I hereby authorize,_____, to release the medical records of the patient listed below.

☐ I hereby authorize, Eastern New Mexico Foot & Ankle, to release the medical records of the patient listed below.

_____
Patient Name

_____
Date of Birth

TO:

_____

_____

_____

Information Needed:

_____ All Records	_____ Outpatient Progress Notes	_____Hospital Stay
_____ Hospital Discharge Summary	_____ Laboratory	_____ Operative Report
_____ Pathology Report	_____ Other: _____	

Please fax records to: (575) 935-3669

OR Mail records to:
Eastern New Mexico Foot & Ankle
921 E 21st Street, Suite C, Clovis, NM 88101

_____ _____
Signature of Patient/Parent/Legal Guardian Date