DERMATOLOGY PARTNERS
of Northern New Mexico
Brad Bowden, MD + Allison Legler, MD

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Section 1- Patient Information:

Last Name: _____ First Name: _____ Middle: _____

Other Name Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Home Phone: _____ Cell Phone _____ Work Phone: _____

Section 2 – Record Request

I hereby request access to the protected health information in my medical record maintained or created by the following

Clinic &/or Provider Name: **(required)** _____

Clinic &/or Provider: office number: _____ fax number: _____.

Check all that apply (required)

- ☐ Most Recent Clinic/Office Visit Notes
- ☐ Entire Medical Record
- ☐ Other _____
- ☐ Pathology/Labs
- ☐ Visit Date: _____