Perinatal Associates
of NEW MEXICO

Medical Records Release

I, _____ , do hereby authorize you to release all information pertaining to my pregnancy in the form of prenatal lab, and/or delivery records to:

Perinatal Associates of New Mexico, Ltd.
201 Cedar SE, Suite 405
Albuquerque, NM 87106
505.764.9535

PRINT NAME OF PATIENT _____ DOB _____

SIGNATURE OF PATIENT OR GUARDIAN _____

DATE _____ SOCIAL SECURITY # _____ RELATIONSHIP _____

☐ I also authorize a photo copy of this release be accepted with the same authority as the original

PATIENT INITIALS _____ EMPLOYEE SIGNATURE _____