

AUTHORIZATION FOR REVIEW OF MEDICAL RECORDS

REFERENCE PATIENT: _____

DATE OF BIRTH: ____/____/____

ADDRESS: _____

You are hereby authorized to allow ***INTERNAL AFFAIRS*** of the Bernalillo County Sheriff's Department access to my medical and therapeutic record for the purposes of review, and further authorize that copies are to be provided as required. No limitations are placed on dates, history of illness, diagnostic or therapeutic information, including any treatment for alcohol and/or drug abuse.

LIMITATIONS TO THE FOREGOING STATEMENT ARE AS FOLLOWS:

- THERE ARE **NO** LIMITATIONS CLAIMED

- RECORDS OF HOSPITALIZATION FROM ____ TO ____

- RECORDS OF EMERGENCY ROOM TREATMENT ON ____ TO ____

I acknowledge that the hospital or care facility is not responsible for the consequences resulting from the use of the records or information specified above by the person or organization to which the disclosure is directed. I also acknowledge that I have read and understand this authorization before signing it and that I signed this authorization at the date and time shown.

Detective/Deputy

Date: ____/____/____
Time: _____

Patient or Patient's Representative

Date: ____/____/____
Time: _____