

New Mexico
CLINICAL RESEARCH & OSTEOPOROSIS CENTER, INC.

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PERMISSION TO RELEASE LABORATORY AND X-RAY RESULTS

Please initial all "Yes" answers:

By signing and initialing this authorization form, I grant my physicians and/or their staff to report laboratory and x-ray results by means of:

YES	NO	
_____	_____	Home answering machine/voice mail (patient identified)
_____	_____	Work voice mail (patient identified)
_____	_____	Message with spouse
_____	_____	Message with family member - _____
_____	_____	Please report results to me only, either by direct phone contact or personal mail.
_____	_____	Other

Signature

Date

Name (print)

Date of Birth