



# MILLENNIUM HEALTH & WELLNESS

**Brian R Hesser, DC-APC, CFNP**  
Advanced Practice Chiropractic Physician  
Certified Family Nurse Practitioner

**Jonathan Smith, DC**  
Chiropractic Physician

**Greg Noel, PT, MS, OMT**  
Physical Therapist

**Joseph Dizon, DPT**  
Physical Therapist

**Monty Barry, PT, dip MDT**  
Physical Therapist

---

**3850 E. Lohman Ste. 100 • Las Cruces, NM 88011 • (575) 521-0793 • Fax (575) 532-1607**

## Record Release Authorization

**FROM: Doctor/Hospital** (one form per facility/doctor)

Address \_\_\_\_\_

Phone/Fax \_\_\_\_\_

*By signing this Medical Request, I hereby authorize the release of my*

**Most Recent Visit Note & Most Recent Imaging Report (within the last 12 Months)**

If needing any specific records please indicate below

**Other:** \_\_\_\_\_

\*\* Note: if these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, mental health, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

I hereby authorize and request the release of my medical records to:

**Millennium Health & Wellness  
3850 E. Lohman Ave. Ste. 100  
Las Cruces, NM 88011  
(575) 521-0793 phone  
(575) 532-1607 fax**

*Thank you in advance for your cooperation*

\_\_\_\_\_  
Patient's Signature/Signature of Parent/Guardian (if a minor)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
SSN# (at least the last 4 digits)

\_\_\_\_\_  
Witness to the above Signatures

\_\_\_\_\_  
Witness Name (Please Print)

\_\_\_\_\_  
Initials of person sending Request

\_\_\_\_\_  
Date of when Release was sent