

OF NEW MEXICO

303 MULBERRY NE • ALBUQUERQUE, NEW MEXICO • 87106

(505) 243-9739 PHONE • (800) 321-4977 TOLL FREE

(505) 842-0650 FAX

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME _____ SS # _____
 DATE OF BIRTH _____ PHONE _____

I HEREBY AUTHORIZE: PHYSICIAN/FACILITY _____
 TO RELEASE MY MEDICAL RECORDS CONCERNING THE FOLLOWING:
 ALL RECORDS: YES NO OTHER (SPECIFY) _____

DATES OF SERVICE FOR WHICH RECORDS ARE REQUESTED: ALL DATES OTHER: _____
 THE ABOVE DESCRIBED RECORDS ARE TO BE RELEASED TO:

 ADDRESS _____ CITY _____ STATE _____ ZIP _____
FOR THE PURPOSE OF:
 RELOCATING TO ANOTHER CITY/STATE
 CHANGING OPHTHALMOLOGIST
 DISABILITY FORM
 ATTORNEY USE
 HEALTH/LIFE INSURANCE INFORMATION
 OTHER _____

PLEASE INITIAL IF YOU WANT THIS INFORMATION TO BE SENT WITH YOUR RECORDS:
 _____ RESULTS OF MY HIV TEST.
 _____ RESULTS OF MY DRUG OR ALCOHOL TESTING.
 _____ INFORMATION ABOUT MY PSYCHIATRIC/PSYCHOLOGICAL TESTING/TREATMENT.

◦ I hereby release the health care provider from all legal responsibility or liability that may arise from the authorization given above. A copy of the authorization shall serve the same purpose as the original.
 ◦ I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the privacy officer at the releasing facility. I understand that a revocation is not effective to the extent that the releasing facility has relied on the use or disclosure of the protected health information.
 ◦ I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
 ◦ The releasing facility will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
 ◦ I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE _____ DATE _____ REPRESENTATIVE (ID VERIFIED) _____ RELATIONSHIP TO PATIENT _____