FAMILY EYE CARE CHILDREN'S EYE CENTER
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 _____

DATE OF BIRTH _____ **PHONE** _____

I HEAR BY AUTHORIZE: PHYSICIAN/FACILITY Family Eye Care & Children's Eye Center of NM

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:

Fax #: (_____)_____

Phone #: (_____)_____

_____

_____

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 extend the state law provides greater access rights).

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

 THIS AUTHORIZATION SHALL EXPIRE IN SIX MONTHS UNLESS OTHERWISE SPECIFIED _____