AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME:_____ MR#_____

DATE/TIME OF SIGNING:_____ BIRTHDATE_____ PHONE_____

I hereby authorize release of medical records by:_____
(DOCTOR/HOSPITAL)

ADDRESS:_____ CITY/STATE:_____

Records Requested:

☐ Laboratory Reports ☐ Office Notes/Testing ☐ Radiology Reports
☐ History/Physical ☐ Skin Test Result ☐ Immunization Records
☐ Pulmonary Function Test ☐ Other: _____

The above described records are to be released to:

_____
(Specify name and address of receiving party)

For the purpose of: ☐ Continuing Care ☐ Insurance Information ☐ Attorney Use
☐ Personal Use ☐ Other (specify)_____

This authorization shall expire in ONE YEAR unless otherwise specified:

_____
(Specify date, event, or conditions of expiration)

Initials below indicate that the specified records are included in the release.

_____HIV Test Result _____Psychological/Psychiatric Care _____Alcohol/Substance Abuse Care

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 I have the right to examine the information to be disclosed.

I understand that New Mexico law requires the consent of the patient for release of confidential information related to a mental disorder or developmental disability. With this understanding I hereby waive any right to confidentiality arising under New Mexico law and authorize release of medical records or medical information, but to the extent specified above. I understand I have the right to examine and copy the information to be disclosed. I further understand that this consent is not a condition of admission and I make it voluntarily.

There will be a .25 cent charge per page unless the records are to be released to a health care provider or hospital.

Patient_____ Witness_____

Patient cannot sign or authorize because_____

Legal Representitive_____ Relationship to Patient_____

NOTE TO RECIPIENT: This information has been disclosed to you from records whose confidentiality is protected by State/Federal regulations. State/Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.