



# Authorization for Release of Records and Request for Records

Health Services • Curry Hall, Room 131 • 505-562-2321

This form is to confirm your authorization to use or disclose your protected health information for a special purpose.

## Individual Patient (or personal representative) confirming the authorization

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Individual patient's name: \_\_\_\_\_

Your address: \_\_\_\_\_  
Address City State ZIP

Your date of birth: \_\_\_\_\_ Your phone number: \_\_\_\_\_

Your Social Security Number: \_\_\_\_\_

## The use and/or disclosure authorized

The following records will be released to the entity listed below. Mark all that is applicable.

- All patient records
- Operative reports
- HIV
- Pap smear
- Pathology report
- Prenatal
- Log of Depo Provera shot
- Lab/X-ray/Ultrasound
- H&P
- Discharge summary
- Progress notes
- STDs
- Other records (Please specify.) \_\_\_\_\_

## Receive records

Name the people and/or organizations (or physician/hospital) that you are authorizing to **receive** and use your protected health information.

## Release records

Name the people and/or organizations (or physician/hospital) that you are authorizing to **release** and use your protected health information.

## Contact Information

Health Services  
ENMU Station 31  
1500 S. Ave. K  
Portales, NM 88130  
Phone: 505-562-2321  
Fax: 505-562-2324

# Individual Patient's Authorization

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

Please check:

- Moving  Transfer care  Patient's request
- O.B. patient who is traveling and needs records
- Other (Please specify.) \_\_\_\_\_

## Ending this authorization

This authorization will end on the following date: \_\_\_\_\_

If expiration date is not noted, this authorization expires one year from date below.

## Changing your mind about this authorization

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officers at your office. However, I understand that I may not revoke this authorization for any actions before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

## Signing this authorization is not a condition of treatment

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations. The authorization may include release of sexually diseases, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), developmental disabilities or behavioral and mental health services or conditions, and treatment for alcohol or drug use.

## Individual patient's signatures

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this authorization is signed by a personal representative for the individual patient:

**Personal representative's name** (Print name.): \_\_\_\_\_

**Signature:** \_\_\_\_\_

Relationship to individual patient: \_\_\_\_\_

## You have the right to have a copy of this form after you sign it.

Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.