Authorization for Release of Medical Record Information

Cppy fee to send records to patients: First 30 pages $30; after 30 pages $025 each.
No charge to fax to your new physician.

Patient Name: _____ Date of Birth: _____
Address: _____
_____
Phone: _____ Alt. Phone: _____

Above listed patient authorizes the following healthcare facility to disclose records:
Integrative Medical Center of NM
1155 Commerce, Ste. C, Las Cruces NM 88011
Ph: (575) 524-3720 Fax: (575) 524-3721

Dates and type of information to disclose:
___ 2 years prior
___Other dates: _____
___All Medical Records
___Laboratory/pathology
___X-ray/radiology
___ Other (specify): _____

The purpose of disclosure is:
___Change of Insurance or Physician
___Continuation of Care (i.e. VA Med Ctr, Hospital)
___Consultative Medical Care
___Referral
___Other _____

Above listed patient requests records be sent to:
Facility Name: _____ Physician Name: _____
Facility Address: _____ Facility Phone: _____
Facility City, ST, Zip: _____ Facility Fax: _____

I understand the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or mental health.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand that under the HIPAA Privacy Rule, my health care provider and/or covered entity must act on my request for access no later than 30 calendar days after receipt of this request. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____
Signature of patient/ parent/ guardian or authorized representative
(Guardian or authorized representative must attach documentation of such status.)

_____ _____
Printed name of authorized representative Relationship / capacity to patient

_____
Address and telephone number of authorized representative