Authorization for Release of Medical Record Information

Please note: Copy fee may be charged for medical records.
First 30 pages $30, after 30 pages $0.25 each.

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

FROM - Above patient authorizes our office below to disclose records:

Integrative Medical Center of NM
4535 Northrise Dr., Las Cruces NM 88011
Phone#: (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 _____

Patient would like IMC to send records 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. 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_____ Date: _____
Signature of patient/ parent/ guardian or authorized representative
(Guardian or authorized representative must attach documentation of such status.)

_____ _____
Printed name of authorized representative Relationship to patient

_____
Address and telephone number of authorized representative