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: ____________________________________

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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

Patient would like IMC to send records to the following:

Patient Name/Facility Name: ______________________________ Physician Name: ______________________________

Patient/Facility Address: ___________________________________ Patient/Facility Phone: _________________________

Patient/Facility City, ST, Zip: _________________________________ Patient Fax: _____________________________

Dates and type of information to disclose:

- ☐ 2 years prior
- ☐ Other dates: ___________________________
- ☐ All Medical Records
- ☐ Laboratory/pathology
- ☐ X-ray/radiology
- ☐ Other: ________________________

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (i.e. VA Med Ctr, Hospital)
- ☐ Consultative Medical Care
- ☐ Referral
- ☐ Other ______________________________

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 u nderstand 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 to patient

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Address and telephone number of authorized representative