WOMEN'S MEDICAL CENTER

2000 W 21st A1 Clovis, NM 88101 Phone: 575-762-8055 Fax: 575-763-3351

AUTHORIZATION FOR RELEASE OF RECORDS & REQUEST FOR RECORDS

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

Please note that per the New Mexico statute 16.10.17.8 NMAC there will be a charge for copies of medical records. 16.10.17.8 NMAC B. A reasonable charge is not more than $10 for the first 15 pages and $0.25 per page thereafter.

1. 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: _____

Your Date of Birth: _____

Your Telephone Number: _____

Your Social Security Number: _____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

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

- ☐ **Pap Smear**
- ☐ **Log of Depo Provera Inj.**
- ☐ **Discharge Summary**
- ☐ **H&P**
- ☐ **Operative Reports**
- ☐ **Pathology Reports**
- ☐ **Lab/X-ray/Ultrasound**
- ☐ **Progress Notes**
- ☐ **HIV**
- ☐ **Pre-natal** (may include STDs & HIV Results)
- ☐ **STDs**
- ☐ **Other Records, please specify:** _____

_____

Circle one of the two options:

RECEIVE RECORDS

Name the people and/or organizations (or Physicians/Hospital) that you are authorizing to **RECEIVE** and use your protected health information.

_____

_____

RELEASE RECORDS

Name the people and/or organizations (or Physicians/Hospital) that you are authorizing to **RELEASE** and use your protected health information.

_____

_____

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** ☐ **OB Patient who is traveling & needs records**

☐ **Other, please specify:** _____

3. 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.

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken 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.

5. 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. This authorization may include release of sexually transmitted 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.

6. INDIVIDUAL PATIENT'S SIGNATURE

I have made 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 form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____
PRINT NAME

_____
SIGNATURE

Relationship to Individual Patient: _____

YOU HAVE A 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.