New Mexico Family Clinic

3901 Georgia St Suite A1 NE • Albuquerque, New Mexico 87110 • Phone (505) 881-4012 • Fax (505) 881-4898

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM OTHER HEALTHCARE FACILITIES

Patient Name: _______________________________________ SS# ___________________________________
Date of Birth: ______/ ______ / ______ Telephone # ____
Address: _______________________________________
City: ____ State: ________________ Zip: __________________

Name of Healthcare Facility from which Records are Requested:
____
Address:____
City: ____ State: ___________ Zip _____________
Phone:___________________________ Fax:____________________________

Dates of treatment requested: ____
Reason for Disclosure: ____

Mail information to:
New Mexico Family Clinic
3901 Georgia St. Suite A1
Albuquerque, NM 87110
Phone: 505-881-4012

OR

Fax to:
505-881-4898

Email Information to:
nmfamilyclinic@gmail.com

I hereby authorize Health Clinic of New Mexico to obtain the health information indicated below that is contained in my patient records to the recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses.

	Physical Health		Alcohol & Drug Abuse
	Mental Health		HIV/AIDS & STD

This authorization does not include permission to release outpatient psychotherapy notes. The release of psychotherapy notes requires a separate authorization.

	Emergency Department Reports		Pathology Reports
	Discharge Summary		Laboratory Reports
	History & Physical		Radiology Reports
	EKG's		Operative Reports
	Physical/Occupational Therapy Reports		Other (Specify)

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below.

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, re-disclosure of your health care information by the recipient may not longer be protected by law.

_______________________________________ / _______________________________________ Date: ____________
Signature of patient/patient's representative* Printed Name

____
Relationship if not patient

* If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request. (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: Parent signing for patient under the age of 18.