Guadalupe Psychiatric and Mental Health Services, PC

Authorization to Release or Obtain Health Information

Name			Request Date
Mailing Address			Telephone #
City	State	Zip Code	Social Security #

I AUTHORIZE

Name:_____

Mailing Address:_____

City, State, Zip Code:_____

Relationship:_____ Telephone #_____ Fax #_____

☐ **To Release Information TO** ☐ **To Obtain Information FROM**

Name:_____

Mailing Address:_____

City, State, Zip Code:_____

Relationship:_____ Telephone #_____ Fax #_____

The purpose of the authorization is: (Select the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation Act ☐ Changing Medical Providers

☐ Participation in Research Study ☐ Marketing ☐ Creating Health Information for Disclosure to a Third Party

☐ Other: (Specify) _____

I authorize the release of the following health information: (Place an "X" in the box(es) that apply to the information you want released or you want to obtain. Authorization for release of psychotherapy notes may not be combined with authorization for release of other medical records - use separate forms if needed.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Treatment Plan ☐ Prescriptions

☐ Immunizations ☐ Hospital Discharged Summary ☐ Laboratory Results ☐ Imaging Reports

☐ Psychotherapy Notes

☐ Records from (date) _____ to (date) _____

☐ Records related to the following specific conditions(s), test(s) or treatments(s):

_____

☐ Other: _____

This authorization shall expire (date or event):_____. I understand that if I do not specify an expiration date, this authorization will expire six months from the date on which it was signed.

I understand that I may revoke this authorization at any time in writing.

I have read and understand the *Important Information about Authorization* contained on the back of this page.

_____ _____

Signature of Individual or Personal Representative Authorized by law Date

If Signed by Personal Representative, basis of Authority: _____

Guadalupe Psychiatric and Mental Health Services, PC

Authorization to Release or Obtain Health Information

1350 Jackie Rd SE, Suite 104

Rio Rancho, NM 87124

Phone: 505.515.3982 Fax: 505.792.6060

Patient Full Name: _____DOB_____

The office of Guadalupe Psychiatry will provide your records to you once you have completed the Authorization to Release or Obtain Health Information form. You can find this form on our website or you can contact our office and we can mail or fax the form to you. Please be sure to sign the form. Unsigned requests cannot be processed.

Your request will be processed and fulfilled within 30 working days. We will either mail or fax the records to the information you provide on the authorization form.

Listed below are changes for copying medication records following NM State Law 16.10.7NMAC.

- $30 for the first 15 pages
- 15+ pages will be 25 cents per page.

In order to comply with federal laws including HIPAA, as well as New Mexico state and federal statues, this office must have a signed authorization from the patient / responsible party stating who we are authorized to release information to. You can find this form on our website or you can contact our office and we can mail or fax the form to you. Please be sure to sign the form. Unsigned requests cannot be processed.

_____ _____

Signature of Patient or Responsible Party: Date:

Payment Type:

Cash Check Money Order Debit/Credit

FOR OFFICE USE ONLY

Date Request Filled _____
By:_____
Account #
Identification Presented: YES or NO Pages:_____ Fee Collected:_____