Isleta Health Center
PO Box 580 | 1 Sagebrush Street
Isleta, NM 87022

Phone: 505-869-3200
Fax: 505-869-4578

RELEASE OF MEDICAL INFORMATION

This authorization allows the Isleta Health Center to disclose confidential medical information about you. You are entitled to a copy of the completed authorization. **There may be fees charged for any copying associated with this request.** If you are a person with a disability and you require this authorization in an alternative format or require a special accommodation to complete this form, you may request assistance from staff at the Isleta Health Center.

Patient		
	Patient Name (First, Last) *(Please print)*	Date of Birth (mm/dd/yyyy) / /
	Patient Address (Street or P.O. Box, City, State, Zip Code)	
	Phone Number:	

1. This authorization applies to medical information **to be released by**:

Name of Individual or Organization
Isleta Health Center
Individual or Organization Address (No. and Street, City, State, Zip Code)
PO Box 580 – 1 Sagebrush Street – Isleta, NM 87022

2. The purpose/need for this disclosure is: _____
   (If the patient initiates the authorization and does not elect to provide a statement of purpose, then statement, "at the request of the individual" is adequate).
3. Date(s) of service: _____
4. The information to be disclosed from my medical record ***(please initial all selections made in this section)***:
   a. ❒ Immunization Record _____ b. ❒ X-ray Reports _____ c. ❒ Laboratory Results _____
   d. ❒ Progress Notes (PCC notes) _____ e. ❒ Physical Exam _____ f. ❒ Entire Record _____
   g. ❒ Copies from other health care facilities for continuum of care (specify): _____
   h. ❒ Other (must be specific): _____

   If you would like any of the following sensitive information disclosed, check the applicable boxes below:
   ❒Alcohol/Drug Use/Abuse ❒HIV/AIDS ❒Mental Health ❒Sexually Transmitted Diseases
   ❒Psychotherapy notes ONLY (by checking this box, I am waiving any psychotherapist-patient privileges)
5. **This medical information shall be disclosed to** and used by the following individual or organization: (Please print)

Name of Individual or Organization
Individual or Organization Address (No. and Street, City, State, Zip Code)

6. This authorization will **expire** in six (6) months unless another expiration date is specified here: ____/____/____*(mm/dd/yyyy)*

STATEMENT OF UNDERSTANDING: I understand that I have a right to revoke this authorization in writing at any time to the Medical Record Department and that the revocation will not apply to information that has already been released in response to this authorization. This authorization is invalid if the expiration date is passed or if the circumstance no longer exists. 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. I understand that unless I revoke this authorization as stated above, this authorization will expire in six (6) months unless I have specified a different date of expiration. I understand that authorizing the disclosure of this medical information is voluntary. I can refuse to sign this authorization; I need not sign this form in order to receive treatment from IHC. I understand that I may inspect or receive copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the re-disclosure may not be protected by federal confidentiality rules. I have a right to limit the information disclosed.

7. I authorize the use or disclosure of the medical information as described above.

Signature		
	Signature of Patient or Personal Representative	Date (mm/dd/yyyy) / /
	If Signed by Personal Representative, Relationship to Patient	
	Signature of Witness	Date (mm/dd/yyyy) / /