NEW MEXICO NEUROLOGY ASSOCIATES, P.C. **MANUEL A. GURULE**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name_____SS# _____

Date of Birth_____Phone # _____

I hereby authorize Dr. /Facility_____to release medical records of myself, including any records pertaining to HIV/AIDS, psychiatric/psychological testing, and/or drug and alcohol tests.

Please include the following:

History & Physical Laboratory/Pathology Reports Progress Notes Radiology Reports
Other_____

Date(s) of service for which records are requested: _____

The above described records are to be release to:

Name Address Phone #

For the purpose of:

_____Continuing Care _____Insurance Purposes _____Attorney Use _____Personal Use

I herby release the healthcare provider from all legal responsibility or liability that may arise from the authorization given above. A copy of the authorization shall serve the same purpose as the original. I understand I have the right to examine the information to be disclosed.

Patient/Responsible Party Signature_____Date_____

Relationship to Patient _____

This authorization shall expire in ONE YEAR unless otherwise specified. _____

NOTICE TO RECIPIENT

This information has been disclosed to you from records whose confidentiality is protected by State/Federal Regulations. State/Federal Regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.