New Mexico Bone and Joint Institute
2301 Indian Wells Road, Suite A
Alamogordo, NM 88310
Phone: (575) 434-0639
Fax: (575) 434-4148

0Authorization to Disclose Protected Health Information

RELEASE INFORMATION FROM:

New Mexico Bone and Joint Institute

3201 Indian Wells Rd

Suite A

Alamogordo, NM 88310

Phone**: (575) 434-0639**

Fax: **(575) 434-4148**

RELEASE INFORMATION TO:

Name: _____

Address: _____

_____

_____

Phone #: _____

Fax #: _____

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

PATIENT'S FULL NAME: _____

DATE OF BIRTH: _____/_____/_____

PHONE #: _____

ADDRESS: _____
(Mailing Address, City, State, Zip)

1. **I authorize permission to**
   - ☐ Disclose medical records/information.
   - ☐ Release a copy of medical records.

2. **Information authorized for disclosure**, *if included in my records*:
   - ☐ History & Physical
   - ☐ Medical/Surgical History
   - ☐ Physician Office Visits
   - ☐ Medication List
   - ☐ Test Results (lab, X-ray, etc.) Please specify:_____
   - ☐ Other Assessments
   - ☐ Discharge Summary
   - ☐ Physical Therapy Notes
   - ☐ Occupation Health Records
   - ☐ Body Part: _____ Date of Service: _____/_____/_____
   - ☐ Date(s) of Service: _____/_____/_____ to _____/_____/_____
   - ☐ Other: _____

3. **If applicable, I also give permission** for the following "Sensitive Protected Health Information" to be disclosed *(please initial below)*
   - ☐ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
   - ☐ Behavioral Health Services / Psychiatric Care
   - ☐ Treatment for Alcohol and/or Drug Abuse
   - ☐ Sexually Transmitted Diseases (STD)
   - ☐ Genetic Counseling / Testing

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_____ Initial

I understand that the information disclosed pursuant to this Authorization, with the **exception of** information protected by Federal and/or State regulations regarding confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

4. The **purpose** for which disclosure is authorized (check where applicable):
   - ☐ Continued Medical Care
   - ☐ Insurance
   - ☐ Benefit Eligibility
   - ☐ Immunization
   - ☐ Litigation
   - ☐ Other: _____

5. **I understand** that I have a right to revoke this authorization at any time. **I understand** that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. **I understand** that the revocation will not apply to information that has already been released in response to this authorization**. I understand** that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: Date: _____/_____/_____.
   If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days.

6. I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by **HIPAA** and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

7. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

8. **There is a processing fee of $30.00 for the first 15 pages and an additional $0.25 per page thereafter. The fee must be paid before the records are printed. (**Note** There is no fee for records for continuation of medical care to another physician's office/facility.) Please allow up to 30 days for processing your request.**

9. **Records will be shredded thirty days after notification of pickup, with the fee being non-refundable.**

_____ _____

Patient's Signature (or Legal Representative, Parent or Legal Guardian) **(Relationship if not Patient)**

Date: _____/_____/_____

For Office Use Only

Deposit Collected: $_____

Accepted By (Initials): _____