MANNM | Medical Associates of Northern New Mexico

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Note: One form per facility/provider only.

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: DOB: Chart:

Address: _____

City: _____ State: _____ Zip: _____

Name of Facility to Release Records:_____

_____

Phone: _____

Fax: _____

Send records to: _____

_____

Phone: _____

Fax: _____

PURPOSE OF RELEASE: (Please circle the appropriate option)

Continuing Care (2 years)	Insurance	Hand Carry	Personal Copy
Changing PCP	Legal Claim	Disability Determination	Authorization to pick up
Other (Specify):			
All Medical Records			
From year: _____		To year: _____	

I understand my records may contain sensitive information and will be released, unless I indicate below.
DO NOT RELEASE:
_____ Psychological. Psychiatric or other mental impairment(s) (excludes psychotherapy notes)
_____ Drug abuse, alcoholism or other substance abuse
_____ Gene related impairments (including genetic test results)
_____ Sexually transmitted diseases (STD's) and/or HIV testing or treatment

Unless otherwise revoked, this authorization expires 2 years from the date of signed release form.

Patient/ Legal Guardian signature: _____ Date: _____

Identification of requester of patient information verified? Yes: ____ No: ____ Type: _____
Note: Patients 18 and older must sign their own authorization. The information that relates to privileged information is subject to the following statement: This information has been disclosed to you from our records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of such information without specific written consent of the person to whom the information pertains or is otherwise permitted by state law.

PLEASE FILL OUT THE FORM COMPLETELY. INCOMPLETE FORM IS INVALID.