Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Central Medical Services of Southern NM to receive information from my health record from: **Request: M.D. Office/or Hospital**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be disclosed:**

( ) most recent visit/admission ( ) progress notes ( ) school records

( ) history & physical exam ( ) laboratory tests ( ) psychological evaluation

( ) initial assessment ( ) X-ray reports ( ) physical therapy evaluation

( ) consultation reports ( ) pathology reports ( ) speech & language evaluation

( ) operative report ( ) ER record/outpatient log ( ) Occupational therapy

( ) discharge summary ( ) other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Covering the period(s) of healthcare: from (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 from (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize that this will include information relating to (initial if applicable):**

( ) yes ( ) no acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)

 Infection, or other sexually transmitted diseases \_\_\_\_\_\_\_initial

( ) yes ( ) no behavioral health services/psychiatric care \_\_\_\_\_\_\_initial

( ) yes ( ) no treatment for alcohol and/or drug abuse \_\_\_\_\_\_\_\_initial

I understand that I have the 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 Central Medical Services of Southern NM. 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 contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date on which it was signed.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure healthcare treatment.

Please Mail/FAX the copies of my record to:

Central Medical Services of Southern NM

2170 E. Lohman Ave. Las Cruces, NM 88001 P: 575-524-8888 F: 575-524-8132