MEDICAL RECORDS

| PH: (575) 396-6611 ext. 2754 |
| FAX: (575) 396-1674 |
Email To: medicalrecordsgroup@nlgh.org

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO: ____________________
FACILITY NAME ADDRESS STATE ZIP PHONE/FAX

Patient Name: ____________________ **D.O.B.:** ____________

Address: ____________________ **City:** ____________ **State:** ________

Social Security # *(optional)***:** ____________________ **Telephone #:** ____________

Information to Be Released - Covering the Periods of Health Care:

From (date): ________ **to (date):** ________ **From (date):** ________ **to (date):** ________

Please check type of information to be released:

- ☐ Entire Medical Record
- ☐ History and Physical Exam
- ☐ Laboratory Test Results
- ☐ Other *(specify)* ____________________
- ☐ Pathology Report
- ☐ Consultation Reports
- ☐ X-Ray Reports
- ☐ Discharge Summary
- ☐ Emergency Room Record
- ☐ X-Ray Film / Images
- ☐ Operative Report
- ☐ Progress Notes
- ☐ Itemized Bill

Purpose of Request:

- ☐ Treatment or consultation
- ☐ At the request of the patient
- ☐ Billing or claims payment
- ☐ Other *(specify)* ____________________

Person Authorized to Receive Information:

Name:
Address:
City, State, Zip:
Phone:
Fax:

Drug and/or alcohol Abuse and/or Psychiatric, and/or HIV/AIDS Record Release:

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and /or other sensitive information. I agree to its release. **Check one:** ☐ **Yes** ☐ **No** ________ **Initials**

I understand that if my medical or billing record contains information in reference to HIV/AIDs testing and /or treatment, I agree to its release.
Check one: ☐ **Yes** ☐ **No** ________ **Initials**

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility. Nor-Lea General Hospital, 1600 North Main, Lovington, NM 88260.
Unless revoked, this authorization will expire on the following date or event. ____________________

Re-disclosure:

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The 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.

Signature of patient or personal Representative Who May Request Disclosure:

I authorize Nor-Lea Hospital District to use and disclose the protected health information specified above.

Signature: ____________________ **Date:** ____________

Authority to sign if not patient: ____________________ **Relationship:** ____________

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other** *(specify):* ____________

Verified by: ____________________ **Records Provided:** ____________