1313 E. 32nd Street Silver City, NM 88061

Authorization for the Release of Health Information

Patient Name: _____

Date of Birth: _____ **Medical record Number** _____

1. **I authorize the use or disclosure of the above named individual's health information as described below.**
2. **I hereby authorize** _____ **(the facility) at** _____ _____ **(address) to disclose my individually identifiable health information that may include confidential medical information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) which are protected by provisions set forth in New Mexico House Bill 490 chapter 227 "Human Immunodeficiency Virus Test Act" 1989. It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse information, which is protected by provisions in the Code of Federal Regulations (42 CFR, part 2).**
3. **The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate)**
   - ☐ **Entire Medical record** **From Date** _____ **Thru Date** _____
   - ☐ **The Following portions of the Medical Record** **From Date** _____ **Thru Date** _____

   _____
   _____
   _____
4. **This information may be disclosed to, and used by, the following individual or organization**

   _____
   (address)

   For the purpose of: (optional) _____
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 Medical records Department. 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 conditions, this authorization will expire in sixty (60) days.**
6. **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 assure treatment.**
7. **I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the facility.**
8. **I understand that I must provide the facility with at least two (2) working days advanced notice for copies of records that I would like to pick up at the facility.**
9. **I understand that if I request that records be copied and sent to me that the facility will make a good faith effort to send those records to me in a reasonable amount of time.**
10. **I understand that I must provide the facility with at least twenty-four (24) hour notice before coming to the facility to review records. I understand that I am not allowed to review the records by myself but must have a qualified healthcare GRMC employee with me during the review.**
11. **I understand that if I wish to have copies of records made, then the facility will assess a fee for copying the records.**
12. **I understand that if the copies are of records from another healthcare provider/facility, Gila Regional Medical Center is not responsible for the accuracy/completeness of the information of the other healthcare provider/facility that are copied.**
13. **GRMC will notify me regarding the total amount due for copying and shipping of requested records. I agree that the Facility will only send me the requested information once payment in full has been received.**
14. **I agree to waive all claims against the facility for release of the requested information.**

_____ _____

Signature of Patient or Legally Responsible Representative Date

_____ _____

Signature of Witness Date

Note: If Legal Representative signs, a copy of the Durable Power of Attorney or other legal document granting the right to act in behalf of the Patient must be attached to this authorization. If the patient is deceased, a copy of the legal document stating Legal Representative is the executor or administrator of the patient's estate must be attached to this authorization.

Submit