Infectious Diseases & Internal Medicine Associates, PC

5901 Harper Dr NE
Albuquerque, NM 87109
PH: (505) 848-3730
Fax (505) 848-3732

Patient Authorization for Use and Disclosure Of Protected Health Information (Medical Records Release)

By signing, I authorize Infectious Diseases & Internal Medicine Associates to use and/or disclose certain Protected Health Information (PHI) about me **To / From** (circle one):

____

Facility/Doctor Office/Person's Name

<u>Must</u> provide mailing address: ____

____

Phone Number: ____

This authorization permits Infectious Diseases & Internal Medicine Associates to use and/or disclose the following individually identifiable health information about me (see attached sheet for specifics):

The information will be used or disclosed for the following purpose:
(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")
The purpose(s) is/are provided so that I can make an informed decision whether to allow the release of information.
This authorization will expire on ___________________. (if blank authorization will expire in 90 days)

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Medical Records Department at:

Infectious Diseases & Internal Medicine Associates
Attn: Medical Records Dept.
5901 Harper Dr NE
Albuquerque, NM 87109

__________________________________ __________________________
Signature of Patient or Legal Guardian Relationship to Patient

__________________________________ ______________________
Print Patient's Name Date

____
Print Name of Patient or Legal Guardian, if applicable

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Patient Authorization for Use and Disclosure Cont.

Patient Name: ____ DOB:_________________

Purpose of Request: ☐ At request of the individual
☐ Other: ____

Disclose / Release Information to: ____

Address: ____

____

____

Phone: ____

Fax: ____

Dates of Service(s): ____

Type of Service(s): ☐ All ☐ Labs ☐ X-rays ☐ Notes
☐ Medication ☐ Other: ____________________________________
____
____

Other Comments:____

____

____

____ __________________________
Patient Signature Date

******We do accept records in electronic format******
Please mail if records exceed 10 pages