



ROI

RELEASE OF INFORMATION
AUTHORIZATION/REQUEST FORM

ROID0021 (Rev 01/14/16)

We are not able to process incomplete authorizations. To prevent delays in processing this request please complete all sections of the authorization. Incomplete authorizations will be returned.

Patient Information	Patient Name			
	Address			
	City/State/Zip			
	Phone #		Medical Record #	
	Date of Birth			
RELEASING Facility	Facility Name	Lovelace Medical Group	Lovelace Medical Groups (Centralized Office) Albuquerque, New Mexico Ph# (505) 727-6395 Fax# (505) 727-9590 If you need information from another Lovelace Facility, please specify which facility: _____	
	Address	6701 Jefferson NE		
	City/State/Zip	Albuquerque, New Mexico 87109		
	Phone #	(505) 727-6395		
	Fax #	(505) 727-9590		
REQUESTING Facility	Requester Name			
	Address			
	City/State/Zip			
	Phone #			
	Fax #	<i>If records are to be faxed, please indicate fax #</i>		
If you wish to pick up copies of records, please initial here: <i>Patient/Patient Representative Initials</i> _____				
The requested information will be used for the following purpose(s): <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Disability Determination <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Personal Use				
Date(s) of Service Requested: From _____ To _____				
List specific description of Information to be released	<input type="checkbox"/> Billing Records	<input type="checkbox"/> Facesheet	<input type="checkbox"/> Medication Records	<input type="checkbox"/> Progress Notes
	<input type="checkbox"/> Consultation	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Nursing Records	<input type="checkbox"/> Therapy Records
	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> X-Ray/Imaging Reports	<input type="checkbox"/> Operative Report	<input type="checkbox"/> All Records
	<input type="checkbox"/> EKG's	<input type="checkbox"/> X-Ray/Imaging Films/CD	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Emergency Records	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Physician Orders	
Behavioral Health Records, HIV, STD	<i>If these types of records are being requested, patient must sign below authorizing release.</i>			
	<input type="checkbox"/> Behavioral Health Records _____			
	<input type="checkbox"/> HIV Records _____			
	<input type="checkbox"/> STD Records _____			
Request for Electronic Records <i>(Lovelace Medical Center, Westside & Women's only)</i>	<input type="checkbox"/> I would like to request an electronic copy of my discharge instructions.			
	<input type="checkbox"/> I would like to request an electronic copy of my patient health information as defined here (including test results, problems, medications, allergies, discharge summary, and procedures). I understand the facility has three business days to provide this copy.			

- The person/organization authorized to use/disclose the information will receive compensation for doing so.
 Yes No
- I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for our coverage of services, or ability to obtain treatment, except as provided under the NOTES listed at the bottom of this form.

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- I understand that I may revoke this authorization at any time by notifying the facility releasing records in writing to Lovelace Medical Group, except to the extent that; action has been taken in reliance on this authorization; or if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
- This authorization shall expire _____ [INSERT APPLICABLE DATE OR EVENT]

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient or representative's authority to act for the patient, if applicable

NOTE: If the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, Lovelace Health System reserves the right to deny treatment associated with such research.

NOTE: If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Lovelace Health System reserves the right to deny that health care.

A copy of this signed form will be provided to the patient.

For Office Use Only:

ID Verified Yes No
 Photo ID Yes No
 Type of ID Driver's License Military School Other _____
 Signature Verified Yes No

Verified by _____
Employee Name

Date

