



ROI

ROID0017 (Rev 09/11/16)

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 #	
	Date of Birth	

RELEASING Facility	Facility Name	Lovelace Women's Hospital	<i>If you need information from another Lovelace facility, please specify which facility below:</i> _____ _____
	Address	4701 Montgomery Blvd. NE	
	City/State/Zip	Albuquerque, NM 87109	
	Phone #	(505) 727-7840	
	Fax #	(505) 727-7884	

Receiving Facility/ Individual(s)	Name	
	Address	
	City/State/Zip	
	Phone #	
	Fax #	

**Information to be:**  Mailed to above address  Picked up  Call # above when ready for pickup  Fax to above #

**The requested information will be used for the following purpose(s):**

- Continuity of Care     Disability Determination     Insurance     Legal     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			
	<input type="checkbox"/> Alcohol/Drug Treatment Records			
Patient or Legal Representative Signature Required: _____				

Request for Electronic Records <i>(Lovelace Medical Center, Westside &amp; 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.



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RELEASE OF INFORMATION  
AUTHORIZATION/REQUEST FORM

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- 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.
- I understand that I may revoke this authorization at any time by notifying the facility releasing records in writing to the Lovelace Health System, 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 be in force and effective for one year from the date of signing or until \_\_\_\_\_, at which time this authorization to disclose this protected health information expires.

\_\_\_\_\_  
Signature of patient or patient's legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or patient's legal 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

Type of ID ✓'d  Driver's License  Military  School  Other \_\_\_\_\_

Verified by \_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date