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	☐ Lovelace Medical Group	☐ New Mexico Heart Institute	
	☐ Lovelace Medical Center	☐ Lovelace Roswell Regional Hospital	
	☐ Lovelace Westside Hospital	☐ Lovelace UNM Rehab Hospital	
	☐ Lovelace Women's Hospital	Other facility, please specify which facility below:	
	☐ Heart Hospital of New Mexico		
Receiving Facility/ Individual(s)	**Name**		
	Address		
	City/ State/ Zip		
	Phone#		
	Fax #		

Information to be:	**Requested Format:**	**The requested information will be used for the following purpose(s):**
☐ Mailed to above address	☐ Paper records	☐ Continuity of Care
☐ Picked Up	☐ CD	☐ Disability Determination
(Call when ready for pick up)	☐ Email records	☐ Insurance
☐ Fax to above number	Email Address:_____	☐ Legal
	☐ MyChart	☐ Personal Use

Date(s) of Service Requested: From_____To _____

List specific description of Information to be released				
	☐ Billing Records	☐ Facesheet	☐ Medication Records	☐ Progress Notes
	☐ Consultation	☐ History & Physical	☐ Nursing Records	☐ Therapy Records
	☐ Discharge Summary	☐ X-Ray/Imaging	☐ Operative Report	☐ All Records
	☐ EKG's	☐ Reports X-Ray/Imaging	☐ Pathology Report	☐ Other:
	☐ Emergency Records	☐ Films/CD	☐ Physician Orders	
		☐ Laboratory		

Behavioral Health Records, HIV, STD, Genetic Test Results	*If these types of records are being requested, patient must check applicable box and sign below authorizing release.* ☐ Behavioral Health Records ☐ HIV Records ☐ STD Records ☐ Alcohol/Drug Treatment Records ☐ Genetic Test Results and related records Patient or Legal Representative Signature Required:_____

- 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. 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. Lovelace Health System recognizes a patient's rights under HIPPA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

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

For Office Use Only:

ID Verified ❑ Yes ❑ No

Type of ID ❑ Driver's License ❑ Military ❑ School ❑ Other_____

Verified by_____ _____

Employee Name | Date