

<i>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.</i>				
Patient Information	Patient Name			
	Address			
	City/State/Zip			
	Phone #			
	Date of Birth			
Releasing Facility	<input type="checkbox"/> Lovelace Medical Group		<input type="checkbox"/> New Mexico Heart Institute	
	<input type="checkbox"/> Lovelace Medical Center		<input type="checkbox"/> Lovelace Roswell Regional Hospital	
	<input type="checkbox"/> Lovelace Westside Hospital		<input type="checkbox"/> Lovelace UNM Rehab Hospital	
	<input type="checkbox"/> Lovelace Women’s Hospital		Other facility, please specify which facility below:	
	<input type="checkbox"/> Heart Hospital of New Mexico			
Receiving Facility/ Individual(s)	Name			
	Address			
	City/ State/ Zip			
	Phone#			
	Fax #			
Information to be: <input type="checkbox"/> Mailed to above address <input type="checkbox"/> Picked Up <i>(Call when ready for pick up)</i> <input type="checkbox"/> Fax to above number		Requested Format: <input type="checkbox"/> Paper records <input type="checkbox"/> CD <input type="checkbox"/> Email records Email Address: _____		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	<input type="checkbox"/> Operative Report	<input type="checkbox"/> All Records
	<input type="checkbox"/> EKG's	<input type="checkbox"/> Reports X-Ray/Imaging	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Other:
	<input type="checkbox"/> Emergency Records	<input type="checkbox"/> Films/CD	<input type="checkbox"/> Physician Orders	
		<input type="checkbox"/> Laboratory		

Behavioral Health Records, HIV, STD, Genetic Test Results	<p><i>If these types of records are being requested, patient must check applicable box and sign below authorizing release.</i></p> <p><input type="checkbox"/> Behavioral Health Records</p> <p><input type="checkbox"/> HIV Records</p> <p><input type="checkbox"/> STD Records</p> <p><input type="checkbox"/> Alcohol/Drug Treatment Records</p> <p><input type="checkbox"/> Genetic Test Results and related records</p> <p>Patient or Legal Representative Signature Required: _____</p>
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- 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of ID	<input type="checkbox"/> Driver's License <input type="checkbox"/> Military <input type="checkbox"/> School <input type="checkbox"/> Other _____
Verified by _____	_____
Employee Name	Date