DERMATOLOGY AND SKIN CANCER CENTER OF NEW MEXICO

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION

I, ____, expressly request that the designated record custodian of Dermatology & Skin Cancer Center of New Mexico, P.C., a New Mexico professional corporation, a covered entity under HIPAA, disclose to the entities or individuals indicated in this release, full and complete protected medical information, including the following:

Patient Name:_________________________________Date of Birth: __________________________

Email:_______________________________Social Security Number:__________________________

Mailing address:____

Phone number: _______________________________

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, psychotherapy notes, correspondence, test results, statements, questionnaires/histories, photographs, videotapes; telephone messages, and records by other medical providers.

I understand that the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus(HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I authorize the release or disclosure of this type of information.

Dermatology & Skin Cancer Center of New Mexico is authorized to:

⬜Send records to the following:

Provider Name: ___________________________________Phone #: _______________________

Provider Address: ____

⬜Release information to the following person(s)

Name: ____Phone #: __________________________

Relationship:___________________________________

Information to be disclosed:

- ⬜ Complete Health Record
- ⬜ Chart Notes
- ⬜ Pathology Reports
- ⬜ Last Office Visit Notes
- ⬜ Bloodwork/Lab Reports
- ⬜ Other:___________________

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I am requesting records from:

- ⬜ Last Six Months
- ⬜ Last Year
- ⬜ Entire Record
- ⬜ Specific Date:_______________

The purpose of this disclosure is for:

- ⬜ Personal Records
- ⬜ Continuity of care with another provider
- ⬜ Other:____

I understand the following:

- *I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.*
- *The information released in response to this authorization may be re-disclosed to other parties.*
- *My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.*

Any Facsimile, copy or photocopy of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until one year from date of execution at which time this authorization expires.

____ ________________________________

{PATIENTS SIGNATURE} DATE

OR

____ ________________________________

{SIGNATURE OF PATIENT'S AUTHORIZED AGENT} DATE

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{DESCRIPTION OF AGENT'S AUTHORITY}