HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

TO: DERMATOLOGY & SKIN CANCER CENTER OF NEW MEXICO, P.C.
6200 UPTOWN BOULEVARD NE, SUITE 410
ALBUQUERQUE, NM 87110
Phone Number: (505) 243-7546
Fax Number: (505) 243-7547

RE: Patient Name: ____

Date of Birth: ____

Social Security Number: ____

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:

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, correspondence, photographs, videotapes; telephone messages, and records by other medical providers.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I am requesting that this protected health information be disclosed for the following purposes:

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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.

DERMATOLOGY & SKIN CANCER CENTER OF NEW MEXICO, P.C. is authorized to release records and disclose information to the following entities or individuals:

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I understand the following:

a. 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.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of tis authorization.

Any Facsimile, copy or photocopy of the 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.

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[PATIENT'S SIGNATURE] DATE

OR

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[SIGNATURE OF PATIENT'S AUTHORIZED AGENT] DATE

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[DESCRIPTION OF AGENT'S AUTHORITY]