NEW MEXICO CARDIOVASCULAR
AUTHORIZATION/REQUISTION (circle one)
FOR RELEASE OF INFORMATION
PHONE: (575) 532-6806 FAX: (575) 532-8033

SECTION A: (This section to be completed by the patient)

Patient's Name: _____ Medical Record #/ID number: _____
Date of Birth: _____ Social Security Number: _____

I hereby authorize **NMCVA** to use/disclose my individually identifiable health information in the manner described within this authorization. I understand that this authorization is voluntary and that if the person or entity authorized by this document is not a health plan or health-care provider that my information may no longer by protected from further disclosure by state or federal law.

List the specific information that is authorized for disclosure:

Dates of Service/Encounter to be released: _____

☐ Anesthesia	☐ Consultation	☐ Discharge Sum	☐ EKG's	☐ Emergency	☐ Face sheet
☐ History/Phys	☐ Imaging Rpts	☐ Laboratory	☐ Medication	☐ Nursing	☐ Surgery/Proc
☐ Orders	☐ Outpatient	☐ Pathology	☐ Progress Nts	☐ Billing Rec	☐ UB 92
☐ Itemized Bill	☐ Acc of Discl	☐ Entire Record	☐ Other	☐ X-ray films	☐ _____

Information Released to/from:
Name: _____
Address: _____
City/St/Zip _____
Phone #: _____ Fax #: _____

SECTION B: This section to be completed by Providers if disclosure is for own purposes:

Purpose of Disclosure: _____

Facility/Practice will receive financial or "in-kind" compensation for the use/disclosure of the information described above? ☐ YES ☐ NO

SECTION C: (Patient must read and complete information in this section)

- I understand my health care will not be affected if I do not sign this form.
- I understand that this authorization will expire on _____ (date) or _____ (event).
- I understand that I may revoke this authorization at any time by notifying **NMCVA** in writing, except to the extent that has already taken in reliance of the previous authorization period.
- I understand that, if requested, I have the right to receive a copy of this authorization/request.
- I understand that if my records contain sensitive information, I may need to have my physician authorize the use or disclosure of it.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that unless restricted by individual state laws, that this information may contain information about HIV, AID, venereal disease, or mental health disorders. I understand, that the exception to this authorization applies to (in accordance with 42 CFR part 2) records containing drug/alcohol abuse or therapist psychiatric notes. These record types require a separate authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulation, the released information may no longer be protected by federal privacy regulations.

Signature of Patient or Patient's Representative_____ **Date**_____

If not signed by patient, please indicate relationship:
☐ Parent or guardian of minor patient ☐ Guardian or conservator of incompetent patient ☐ Beneficiary or representative of deceased patient