

WOMEN'S MEDICAL a s s o c i a t e s

2520 S. Telshor Blvd, Las Cruces, NM 88011 – (575) 522-9793 Fax (575) 532-9019

RECORDS RELEASED FROM WMA

Standard Authorization of Use and Disclosure of Protected Health Information
Information to be Used or Disclosed (Information you want released)
Information to be covered by this authorization includes:

If you would like any of the following released, we need your initials by them or we cannot include them in your request.

_____ Psychiatric Notes _____ Alcohol Use _____ Drug Use _____ HIV/AIDS Records _____ STD Records

Purposes of Disclosure (Why you want the information released)

Information listed above will be disclosed for the following purposes:

Persons Authorized to Use or Disclose Information (Who you want to release the information)

Information listed above will be used or disclosed by: Women's Medical Associates' Providers and/or Staff

Information described above may be disclosed to:

Name of Provider: _____

Name of Facility: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Expiration Date of Authorization

This authorization is effective through ____/____/____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Women's Medical Associates. You should be contact the Office Manager to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

Rights of the Individual

You may inspect or request a copy of information that is used or disclosed under the authorization

You may refuse to sign this authorization.

Name of Patient (Print or Type) Date of Birth

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

Approved: _____

Released by: _____

Date: _____

Mailed: _____

Faxed: _____

Hold for Patient Pick Up: _____