WOMEN'S MEDICAL
associates

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

Records Released to Patient

Request to obtain a Copy of your Protected Health Information.
Please describe the information that you would like to obtain a copy of

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If you would like any of the following released, we need your initials specifically requesting them
___ Psychiatric Notes ___ Alcohol use ___ Drug Use ___ HIV/AIDS Records ___ STD Records

Reason: ______________________________ (transfer care, moving, traveling, etc.)

Review Procedures
Your request to inspect or obtain a copy of your protected health information will be reviewed by your provider, who will determine if the information requested can be made available to you. We may be legally prohibited from making certain information available to you or your representative, including;

- [ ] psychotherapy notes
- [ ] information related to legal proceedings
- [ ] information that federal or state laws prevent us from disclosing
- [ ] information related to medical research in which you have agreed to participate
- [ ] information whose disclosure may result in harm or injury to you or to another person
- [ ] information obtained under a promise of confidentially

Within the limitations of law, we will make every effort to accommodate your request
We will:

- [ ] complete our review of your request and either arrange for you to inspect your records within 30 days of your request, or
- [ ] Provide you with the copies you request, or
- [ ] provide you with a written explanation of any restriction on the information that we can provide you.

Fees for Coping
If you wish to obtain copies of the information you requested, we will arrange to send it to you. Paper copies will be $30 for 1-15 pages and then 25 cents a page thereafter. Please provide an address if you would like the copies mailed to you. You may also choose to pick up the records as well.

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If we deny your request, in whole or in past, you may request that we review the decision.

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Name of Patient (Print) Date of Birth

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Signature of Patient

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Signature of Patient Representative

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Relationship of Patient Representative to Patient

Approved: _____________________

Released by: ___________________
Date: __________________________
Mailed: ________________________
Faxed: _________________________
Hold for Patient Pick Up: ________