AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION:

San Juan Regional Medical Center
801 West Maple Street
Farmington, New Mexico 87401
Health Information Management Department
Telephone: (505) 609-6121; Fax: (505) 609-2472

Patient ID verified: Y N
Verified By: _____ Date Needed: _____

Patient Name :_____ Date of Birth: _____/_____/_____ SSN: XXX-XX-_____
Address: _____ City: _____ State: _____ Zip: _____ (Last 4 only)
E-mail Address: _____ Phone: _(_____)_____

I request that my protected health information (PHI) from San Juan Regional Medical Center be disclosed to:
Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):

- □ ER Record
- □ Ambulance / Air Care reports
- □ Discharge Summary
- □ History & Physical
- □ Consultations
- □ Progress Notes
- □ Other: _____
- □ Radiology Reports □ Images on CD
- □ Lab Results / Reports
- □ Operative / Pathology / Cardiac Cath Reports
- □ Dietician Notes
- □ Cardiac Rehab Therapy
- □ PT, OT, ST Therapy Notes
- □ Wound Care Notes

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired or mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records □ Yes □ No Dates: _____
HIV Testing and Results □ Yes □ No Dates: _____
Mental Health Records □ Yes □ No Dates: _____
Psychotherapy Records □ Yes □ No Dates: _____
Genetic Records □ Yes □ No Dates: _____

Covering the period of healthcare from: Specific Date(s): _____ to _____

Purpose for requesting information:

- □ Attorney / Legal **(Fee)**
- □ Commercial Insurance
- □ Worker's Compensation
- □ Uranium Claim
- □ Continued Patient Care _____
- □ Personal Use
- □ IHS Contract Health
- □ Social Security

Disclosure Format (Paper is default if not marked.): □ Hand Carry □ Mail □ Fax

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 801 W. Maple, Farmington, NM 87401. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____, not to exceed one year. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable) Witnessed by

HIM08112020

(For Office Use Only)
Account Number: _____ **Medical Record Number:** _____
Req# _____ □ Completed □ Requested