AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

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: __________

MRN: ________________ Req# _________________

To maintain confidentiality, the patient or legal representative must complete bold items, sign this form and present a picture ID

I hereby authorize you to disclose the following information from the medical records of:

PATIENT NAME: ______________________

DATE OF BIRTH: ______________ **SSN:** XXX-XX-______ (Last 4 only)

ADDRESS: ______________ CITY: ______________

STATE: ________ ZIP: ________ TELEPHONE: ______________

THIS INFORMATION IS TO BE DISCLOSED ☐ **Hand carry** ☐ **Mail** ☐ **Fax**

TO: ______________ **ADDRESS:** ______________

CITY: ________ **STATE:** ________ **ZIP:** ________ **TELEPHONE:** ________

TIME PERIOD OF REQUESTED INFORMATION: FROM: ____________ **TO:** ____________

You have the right to restrict information. Please ONLY check the box for requested documentation.

☐ ER Record
☐ Ambulance / Air Care reports
☐ Discharge Summary
☐ History & Physical
☐ Consultations
☐ Progress Notes
Other: ________________________________

☐ Radiology Reports
☐ Lab Results/Reports
☐ Operative / Pathology / Cardiac Cath Reports
☐ Dietitian Notes
☐ Cardiac Rehab Therapy
☐ PT, OT, ST Therapy Notes
☐ Wound Care Notes

☐ **SJRMC Employees only:** To view or print from computer

☐ HIV/AIDS Related information ☐ Psychological/Psychiatric Evaluation ☐ Drug/Alcohol Related Information

REQUIRES ADDITIONAL SIGNATURE TO DISCLOSE ______________________

PURPOSE OF DISCLOSURE

(*Check only **one** box below)*

☐ Attorney / Legal **(Fee)**
☐ Commercial / Auto Insurance
☐ Worker's Compensation
☐ Uranium Claim **(Fee)**
☐ Social Security

☐ Continued Patient Care ________________
(Provider/Clinic needed in "TO BE DISCLOSED" area above)

☐ Personal Use **(Fee)**
☐ IHS Contract Health

It is further understood that the information disclosed is for the purpose stated above and may not be provided in whole or in part to any other agency, organization or person. This information has been disclosed to you from records whose confidentiality is protected by State Law. The State Law prohibits you from making further disclosure of such information without specific written consent of the person to whom the information pertains or is otherwise permitted by State Law.

______________________________ ______________________
Signature of patient or legal representative **Date**

______________________________ ______________________
Relationship to Patient Witnessed by

This consent will expire one year after date of signature.

☐ Completed
☐ Requested

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