

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

San Juan Regional Medical Center

San Juan Health Partners Clinic(s) - Please specify which clinic(s): _____

(For Office Use Only)

Account Number: _____ Medical Record Number: _____ Req#: _____

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

Patient Name: _____ Date of Birth: ____/____/____ SSN: XXX-XX-_____
 (Last 4 only)

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Phone: (____) _____

If patient is a minor or unable to sign, please complete the following:

Patient is a minor: ____ years of age Patient is unable to sign because: _____

Authority of representative to sign on behalf of patient:

Parent Legal Guardian Court Order Other: _____

I request that my protected health information (PHI) from San Juan Regional Medical Center/San Juan Health Partners be disclosed to:

Recipient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Phone: (____) _____ Fax: (____) _____

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

<input type="checkbox"/> Ambulance / Air Care reports	<input type="checkbox"/> ER Record	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Billing, Invoices and Statements	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Radiology Reports <input type="checkbox"/> Images on CD
<input type="checkbox"/> Cardiac Rehab Therapy	<input type="checkbox"/> Lab Results / Reports	<input type="checkbox"/> Wound Care Notes
<input type="checkbox"/> Consultations	<input type="checkbox"/> Operative / Pathology / Cardiac Cath Reports	<input type="checkbox"/> Occupational Therapy Notes
<input type="checkbox"/> Dietician Notes	<input type="checkbox"/> Past/Present Medications	<input type="checkbox"/> Physical Therapy Notes
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pharmacy Records	<input type="checkbox"/> Speech Therapy Notes
<input type="checkbox"/> EKG/ECG	<input type="checkbox"/> Other	

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/or AIDs diagnosis Treatment, Testing and Results Yes No Dates: _____

Mental Health Records Yes No Dates: _____

Psychotherapy Records Yes No Dates: _____

Genetic Records Yes No Dates: _____

Any Reproductive Records Yes* No Dates: _____ **If Yes, Attestation for Use or Disclosure of PHI for**

Reproductive Healthcare may be required.

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

Purpose for requesting information:

- | | | |
|---|--|---|
| <input type="checkbox"/> Attorney / Legal (Fee) | <input type="checkbox"/> Uranium Claim | <input type="checkbox"/> Continuity of Care |
| <input type="checkbox"/> Commercial Insurance | <input type="checkbox"/> School | <input type="checkbox"/> At the Request of Individual |
| <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Social Security | <input type="checkbox"/> Other: _____ |

Disclosure Format: Pick up Mail to address above Fax Electronic View on-site

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. I may not be able to revoke this authorization if its purpose was to obtain insurance.
- 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 (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by HIPAA Privacy Standards.
- I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.


Patient or Authorized Representative Signature

Date

Print Name Relationship to Patient (if applicable)

Witnessed by

Approvals Med Dir: NA
 P&T: NA
 HIM: 12/24
 MEC: 01/25
 Orig: UNK
 Revised: 12/24


**SAN JUAN REGIONAL
 MEDICAL CENTER**
 801 West Maple Street
 Farmington, New Mexico 87401