LOS ALAMOS MEDICAL CENTER

RELEASE OF INFORMATION

☐ **AUTHORIZATION** ☐ **REQUISITION** *(Check one)*

SECTION A: This section to be completed by the patient.

Name of Patient:	Medical Record Number:	Social Security Number:	Date of Birth:

Address:		

City:	State:	Zip Code:

Releasing Facility	Facility Name:			
	Address:			
	City:	State:	Zip:	Telephone Number:
Requesting Facility or Individual	Requestor Name:			
	Address:			
	City:	State:	Zip:	Telephone Number:

Date(s) of Service: _____ thru _____

List Specific Description of Information to be Released:

☐ Anesthesia	☐ Discharge Summary	☐ Imaging Reports	☐ Physician Orders	☐ All Records
☐ Billing Records	☐ EKG's	☐ Laboratory	☐ Outpatient Records	☐ Other: _____
☐ UB04	☐ Emergency Records	☐ Medication Records	☐ Pathology Report	☐ _____
☐ Itemized Bills	☐ Face Sheet	☐ Nursing Records	☐ Progress Notes	☐ _____
☐ Consultation	☐ History & Physical	☐ Surgery / Progress Report	☐ Accounting of Disclosure	☐ _____

Do you want the hospital to release your psychotherapy notes (if any) to the person or facility you have listed above? ☐ Yes ☐ No

Describe the purpose / reason for this request: _____

SECTION B: Must be completed by the patient for all authorizations:

The patient or the patient's representative must read / acknowledge the following statements:

1. I understand that the persons hereby authorized to use / disclose information will not condition treatment or payment on my providing this authorization.
2. I understand that this authorization will expire on _____/_____/_____. ***(If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)***
3. I understand that information used or disclosed to any entity other than a health plan or health care provider may be subject to redisclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R. 160 and 164.
4. I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.
5. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
6. I understand that if my records contain sensitive information that this facility may need to have my physician agree to the use or disclosure of it.
7. I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment.

DOB: HSV:
ADMIT: AGE: SEX:
ATT: ROOM/BED /
MR #: #:
PAT #:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary.

FOR OFFICE USE ONLY

Verified: ☐ Yes ☐ No By: _____

License No: _____ SS No: _____

Signature: ☐ Yes ☐ No

_____ _____

Signature of Patient or Legal Representative Date and Time

_____

If Patient Representative – please type in name

_____

Basis for which representative has the authority to act for the patient

_____ _____

Signature of Witness Date and Time

DOB: HSV:
ADMIT: AGE: SEX:
ATT: ROOM/BED /
MR #: #:
PAT #: