LOS ALAMOS MEDICAL CENTER

RELEASE OF INFORMATION

Patient Name: _____ **Date of Birth**: _____ **Medical Record #**: _____

1. I authorize Los Alamos Medical Center to disclose information from my health record at:

Los Alamos Medical Center
3917 West Road
Los Alamos, NM 87544

To: **Name**: _____
Street Address: _____
City: _____ **State**: _____ **Zip**: _____
Phone: _____ **Provider/Facility Fax**: _____

2. Information to be disclosed:

[ ] ER records	[ ] Pathology reports	[ ] Immunization records
[ ] Hospitalization records	[ ] Radiology reports	[ ] Billing
[ ] Surgical/Operative reports	[ ] History & physical exams	[ ] Encounter summary
[ ] Physical therapy records	[ ] Discharge summaries	[ ] All records
[ ] Laboratory results	[ ] Consultation reports	[ ] _____

Date(s) of Service: _____ to _____

Purpose of request: _____

Do you authorize the hospital to release sensitive information such as psychiatric or HIV health information to the party indicated above? [ ] Yes [ ] No

3. I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months from the date on which it was signed.
4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
5. I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this authorization and need not sign this authorization to obtain health care treatment; and that if I authorize the disclosure of this health information, I have the right to examine and copy the information to be disclosed. A copy of this signed authorization will be provided to me.

Signature, Patient, or legal representative (Relationship to patient) (Date)

Signature of Witness (Date) (Parent, if CPH/PFC&A patient over 14) (Date)

PROHIBITION OF REDISCLOSURE: Federal regulations (42 CFR Part2) and State Laws (NMSA 1978 ## 43-1-19, 32A-6A-24-2B-7 and 24-1-9.5) prohibit further disclosure of mental health or alcohol and/or drug abuse treatment information and of the results of tests for HIV/AIDS and other sexually transmitted diseases to any person or agency without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or State laws.