

NEW MEXICO COLON & RECTAL SURGERY ASSOCIATES P.C.

500 Walter NE, Ste 510 Albuquerque, NM 87102 Phone 243-3514 Fax 243-3451

Authorization for Release of Medical Information

Patient Name: _____ Social Security # _____

Date of Birth: _____ Phone # _____

I hereby authorize Dr./Facility _____ to release medical records of myself concerning the following.

Records requested:

- History & Physical Laboratory Report Pathology Report
- Progress Notes Radiology Report Other _____

Date(s) of service for which records are requested _____

The above described records are to be released to:

Name	Address
------	---------

For the purpose of:

- Continuing Care Insurance Information Other _____
- Attorney Use Personal Use

Please initial if you want this information to be sent with your records:

- _____ Results of my HIV test.
- _____ Results of my drug or alcohol testing
- _____ Information regarding my psychiatric/psychological testing/treatment.

I hereby release the health care provider from all legal responsibility or liability that may arise from the authorization given above. A copy of the authorization shall serve the same purpose as the original. I understand I have the right to examine the information to be disclosed.

_____ or _____	
Patient (ID verified)	Legal Representative (ID verified)

Date of Signing	Relationship to Patient
-----------------	-------------------------

This authorization shall expire in ONE YEAR unless otherwise specified _____

Patient cannot sign or authorize because _____

Witness

Note to Recipient: This information has been disclosed to you from records whose confidentiality is protected by State/Federal regulations. State/Federal regulations prohibit you from making any further disclosure of it without the specified written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.