Emp. Init. _____

New Pueblo Medicine Records Release/Request

Patient Name: _____ Date of Birth: _____

I. **My Authorization**

You may release the following health care information:

[ ] My health information relating to the following treatment/condition or for the following dates:
_____

[ ] All my health information including, but not limited to, AIDS/HIV and other communicable disease information, behavioral health care/ psychiatric care, psychotherapy, alcohol and /or drug abuse treatment, if any, unless specifically excepted: _____
_____

[ ] Other: _____

Medical Office Releasing Records	Medical Office Requesting Records
_____	_____
Physician	Physician
_____	_____
Address	Address
_____	_____
City State Zip	City State Zip
_____	_____
Telephone	Telephone

Requested records to be provided: [ ] Paper [ ] CD [ ] Flash Drive*
***There is a $10 charge for records requested on flash drive.**
Records will be released in paper form unless otherwise indicated.

Reason(s) for this authorization:
[ ] at my request _____
[ ] changing physicians _____
[ ] other (specify) _____

This authorization ends in 6 months unless otherwise indicated.
[ ] on (date) _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are to fill out a revocation form available from the office or write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship