Perinatal Associates
of NEW MEXICO

Authorization For Use/Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide all information requested may invalidate this Authorization.

PATIENTS NAME _____ DOB _____

I hereby authorize:

_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

To release to:

Perinatal Associates of NM

ADDRESS 201 Cedar ST SE

CITY Albuquerque STATE NM ZIP 87106

PHONE (505) 764-9535 FAX (505) 843-9646

The following information to be Released: (Check the appropriate box)

A. ☐ **Routine Record Sets:** (office visit, diagnostic test results, problem list, medications list/allergies, immunizations) Dates of service from_____ to _____

☐ Only the following records or types of health information _____ (Including any dates)

B. I specifically authorize release of the following information (check as appropriate):

☐ Alcohol/drug treatment information

☐ HIV test results

☐ Copies of ultrasound Images from _____ to _____

☐ Mental health treatment information[1]

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE of requested use or discloser: ☐ Patient Request ☐ Other

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

if signed by someone other than the patient, please state your relationship

WITNESS _____ DATE _____

[1] If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.