McLeod Medical Center

PO Box 1925 Edgewood, NM 87015
Ph: (505) 286-2396 ; Fax: (505) 286-2398

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name / Name of Patient: _____ SS#: _____

Address: _____ Phone: _____ Date of Birth: _____

THE ABOVE RECORD IS TO BE RELEASED FROM: McLeod Medical Center
PO Box 1925
Edgewood, NM 87015
Ph:(505) 286-2396;Fax:(505) 286-2398

INFORMATION REQUESTED (X) = □ Complete Medical Record □*Portion of Medical Record
* If only a portion of the medical record is required please specify.
RELEASE INFORMATION TO: Provider/ Facility: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Fax Number: _____

THE RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):
□ Continue Medical Care □ New Primary Care Physician □ Insurance Purposes
□ Personal Interest □ Legal Purposes □ Other (specify): _____

Please initial if you want the following information to be sent with your records:
_____ Results of HIV testing _____ Results of drug or alcohol testing
_____ Information regarding psychiatric / psychological testing / treatment

I hereby release the healthcare provider from all legal responsibility or liability that may arise from the authorization given above.
Patient or Legal Representative Signature: _____ Date: _____
Relationship to Patient: _____

FOR INTERNAL OFFICE USE ONLY:
Date of Authorization received: _____ Date Records Sent: _____
Name of Person Sending Records: _____

REQUEST FOR RECORD COPY RELEASE WILL BE HANDED ON A FIRST COME, FIRST SERVE BASES. PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal and/or state law. Federal and state regulations prohibit you (the recipient) from making any further disclosure without the specific 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

McLeod Medical Center

PO Box 1925 Edgewood, NM 87015
Ph: (505) 286-2396 ; Fax : (505) 286-2398

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name / Name of Patient: _____ SS# _____

Address: _____ Phone: _____Date of Birth: _____
INFORMATION REQUESTED (X)= □ Complete Medical Record □*Portion of Medical Record
* If only a portion of the medical record is required please specify
INFORMATION REQUESTED FROM: Provider/Facility: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Fax: _____
THE ABOVE RECORD IS TO BE RELEASED TO: MCLEOD MEDICAL CENTER
PO BOX 1925
EDGEWOOD, NM 87015
PH: (505) 281-2463 ; FAX: (505) 286-2398

THE RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):
□ Continued Medical Care □ New Primary Care Physician □ Insurance Purposes
□ Personal Interest □ Legal Purposes □ Other (specify): _____
□ All
Please initial if you want the following information to be sent with your records:
_____ Results of HIV testing _____ Results of drug or alcohol testing
_____ Information regarding psychiatric/psychological testing/treatment

I hereby release the healthcare provider from all legal responsibility or liability that may arise from the authorization given above.
Patient or Legal Representative Signature: _____ Date: _____
Relationship to patient: _____
FOR INTERNAL OFFICE USE ONLY:
Date of Authorization received: _____ Date Records Sent: _____
Name of Person Sending Records: _____

REQUEST FOR RECORD COPY RELEASE WILL BE HANDLED ON A FIRST COME, FIRST SERVE BASIS.
PROHIBITION ON RE-DISCLOSURE:
This information has been disclosed to you from records whose confidentiality is protected by federal and/or state law. Federal and state regulations prohibit you (the recipient) from making any further disclosure without the specific 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. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization;or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.