# AUTHORIZATION TO REQUEST HEALTH INFORMATION

Patient Name_____ Date of Birth_____Medical Record # _____
I hereby authorize the UNM Health Sciences Center to receive information from my health record from:

**Requested M.D./or Hospital**
Name: _____
Address: _____

**For the purpose of treatment for:**_____

Information to be disclosed:

| | | |
|---|---|---|
| [ ] most recent visit/admission | [ ] progress notes | [ ] school records |
| [ ] history & physical exam | [ ] laboratory tests | [ ] psychological evaluation |
| [ ] initial assessment | [ ] x-ray reports | [ ] physical therapy evaluation |
| [ ] consultation reports | [ ] pathology reports | [ ] speech & language evaluation |
| [ ] operative report | [ ] ER record/outpatient log | [ ] occupational therapy |
| [ ] discharge summary | | |

[ ] Other (please specify) _____
Covering the period(s) of healthcare: from (date) _____ to (date) _____
from (date) _____ to (date) _____

I authorize that this will include information relating to (initial if applicable):
[ ] yes [ ] no acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, or other sexually transmitted diseases_____initial
[ ] yes [ ] no behavioral health services/psychiatric care_____initial
[ ] yes [ ] no treatment for alcohol and/or drug abuse_____initial

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.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure healthcare treatment.

Please fax the copies of my record to: UNMHSC Clinic: _____ Fax: _____

Please mail the copies of my record to:
[ ] University Hospital, Health Information Mgmt/Medical Record Dept, 2211 Lomas Blvd NE, Albuquerque, NM 87106
[ ] UNM Psychiatric Center, Health Information Mgmt/Medical Record Dept , 2600 Marble NE, Albuquerque, NM 87131
[ ] UNM Children's Psychiatric Center, Health Information Mgmt,1001 Yale Blvd NE, Albuquerque, NM 87131
[ ] Carrie Tingley Hospital, Health Information Mgmt Dept, 1127 University Blvd NE, Albuquerque, NM 87102
[ ] UNM Cancer Research &Treatment Center, Health Information Mgmt Dept, MSC 08 4630,1 University of New Mexico, Albuquerque, NM 87131
[ ] UNMHSC Clinic/Department:_____

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

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