RELEASE OF INFORMATION AUTHORIZATION/REQUEST FORM

ROID0021 (Rev 01/14/16)

We are not able to process incomplete authorizations. To prevent delays in processing this request, please complete all sections of the authorization. Incomplete authorizations will be returned.

Patient Information	Patient Name		
	Address		
	City/State/Zip		
	Phone #		Medical Record #
	Date of Birth		
RELEASING Facility	Facility Name	Lovelace Medical Group	Lovelace Medical Groups (Centralized Office) Albuquerque, New Mexico Ph# (505) 727-6395 Fax# (505) 727-9590
	Address	6701 Jefferson NE	
	City/State/Zip	Albuquerque , New Mexico 87109	If you need information from another Lovelac Facility, please specify which facility:_____
	Phone #	505-727-8197	
	Fax #	505-727-9501 - Routine	
REQUESTING Facility	Requester Name		
	Address		
	City/State/Zip		
	Phone #		
	Fax #	*If records are to be faxed, please indicate fax #*	

If you wish to pick up copies of records, please initial here: *Patient/Patient Representative Initials* _____

The requested information will be used for the following purpose(s):
☐ Continuity of Care ☐ Disability Determination ☐ Insurance ☐ Legal ☐ Personal Use

Date(s) of Service Requested: From_____ To_____

List specific description of Information to be released	☐ Billing Records	☐ Facesheet	☐ Medication Records	☐ Progress Notes
	☐ Consultation	☐ History & Physical	☐ Nursing Records	☐ Therapy Records
	☐ Discharge Summary	☐ X-Ray/Imaging Reports	☐ Operative Report	☐ All Records
	☐ EKG's	☐ X-Ray/Imaging Films/CD	☐ Pathology Report	☐ Other_____
	☐ Emergency Records	☐ Laboratory	☐ Physician Orders	_____

Behavioral Health Records, HIV, STD	*If these types of records are being requested, patient must sign below authorizing release.* ☐ Behavioral Health Records_____ ☐ HIV Records_____ ☐ STD Records_____ ☐ Alcohol/Drug Treatment Records_____
Request for Electronic Records *(Lovelace Medical Center, Westside & Women's only)*	☐ I would like to request an electronic copy of my discharge instructions. ☐ I would like to request an electronic copy of my patient health information as defined here (including test results, problems, medications, allergies, discharge summary, and procedures). I understand the facility has three business days to provide this copy.

- The person/organization authorized to use/disclose the information will receive compensation for doing so.
  ☐ Yes ☐ No
- I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for our coverage of services, or ability to obtain treatment, except as provided under the NOTES listed at the bottom of this form.

- I understand that I may revoke this authorization at any time by notifying the facility releasing records in writing to Lovelace Medical Group, except to the extent that; action has been taken in reliance on this authorization; or if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
- This authorization shall expire_____ [INSERT APPLICABLE DATE OR EVENT]

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient or representative's authority to act for the patient, if applicable

NOTE: If the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, Lovelace Health System reserves the right to deny treatment associated with such research.

NOTE: If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Lovelace Health System reserves the right to deny that health care.

A copy of this signed form will be provided to the patient.

For Office Use Only:

ID Verified ☐ Yes ☐ No
Photo ID ✓'d ☐ Yes ☐ No
Type of ID ✓'d ☐ Driver's License ☐ Military ☐ School ☐ Other_____
Signature Verified ☐ Yes ☐ No

Verified by_____ _____
Employee Name Date