Albuquerque Dermatology Associates and Cutaneous Surgery Center, P.A.
5310 Homestead Road NE Ste. 301
Albuquerque, NM 87110

Phone: 505-872-4700
Fax: 505-872-4709
Email: adrecords@swcp.com

MEDICAL RECORDS RELEASE 1/3

Section I--Patient Information

Name: _____ **Last 4 of social security #:** _____ **Date of birth:**_____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Phone: _____**Email:** _____

I, or my authorized representative, hereby authorize **Albuquerque Dermatology Associates & Cutaneous Surgery Center** and their respective employees, agents and subcontractors to disclose/receive my Personal Health Information (PHI) and Insurance Record as below:

Section II--Provider Information

I request a copy of my records be sent **TO** Albuquerque Dermatology Associates from:

Name: _____

Address:_____

City: _____ **State:**_____ **Zip:**_____

Phone: _____ **Fax:**_____

I request a copy of my records be sent **FROM** Albuquerque Dermatology Associates to:

Name: _____

Address: _____

City: _____ **State:**_____ **Zip:**_____

Phone: _____ **Fax:**_____

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MEDICAL RECORDS RELEASE 2/3

Section III–Information to be Released

Office notes: _____ **Biopsy reports:** _____
Laboratory studies: _____ **Surgical procedures:** _____
Allergy test/treatment: _____ **Other:**
_____
Treatment dates ranging from _____**to** _____
HIV-Related Information: _____
Entire record (excluding medical records sent to ADA/CSC by outside health care providers)**:**_____

Section IV–Reason for Release of Records

Continuing care:_____ **Insurance application*:**_____
Transfer of care: _____ **Personal use*:** _____
Other: _____ * A fee may be charged
Email:_____

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MEDICAL RECORDS RELEASE 3/3

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION** only if I place my initials on the appropriate line in Section III. In the event the health information described below includes any of these types of information, and I initial the line on the box in Section III, I specifically authorize release of such information to the person indicated in Section II.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.

3. I have the right to revoke this authorization at any time by writing to ADA/CSC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in ADA/CSC, or eligibility benefits will not be conditioned upon my authorization of disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient, and the re-disclosure may no longer be protected by federal or state law.

6. This authorization does not authorize you to discuss my personal health information and insurance record with anyone other than the person authorized in section II.

7. I understand that email from ADA/CSC is encrypted for the safety of my personal health information, but that once it arrives at my or my designated party's inbox, ADA/CSC is no longer responsible for that personal health information and it becomes my responsibility to ensure its protection.

8. By signing this form, I am confirming that it accurately reflects my wishes.

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____Zip:_____

Signature of Patient or Representative: _____Date_____