Medical Records Release

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

Section I--Patient Information

Name:_____ **DOB:**_____

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

INFORMATION REQUESTED FROM:

Name:_____

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

Phone:_____**Fax:**_____

SEND INFORMATION TO:

Name:_____

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

Phone:_____**Fax:**_____

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:_____ **Transfer of care:**_____

Insurance application*:_____ **Personal use*:**_____

Other: _____ *** A fee may be charged**

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. 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.

6. 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.

This authorization will expire (date) _____. I understand that if I do not specify an expiration date, this authorization will expire 12 months from the date on which it was signed.

_____

Signature of Individual or Personal Representative Authorized by Law Date

If signed by Personal Representative, basis of authority:_____

For ADA/CSC use only:

_____

Signature of Medical Records Clerk

_____

Date

Records Released