2301 Indian Wells Road Suite B Phone: 575-437-0890 Fax 575-437-0905

INDIVIDUAL AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I. I, _____, hereby voluntarily authorize the verbal disclosure of medical and business information.

PATIENT INFORMATION

Patient Name _____ Date of Birth ____/____/____

Address _____ Patient SS# _____

City/State/Zip _____ Contact # (____) _____-_____

Fax # _____

II. NAME OF PERSON OR ORGANIZATION TO WHOM I AM AUTHORIZING VERBAL RELEASE OF INFORMATION:

Name of Organization/ Person: _____ Contact #:_____

Address: _____ Fax#: _____

City/ State/ Zip: _____

III. The purpose or need for this disclosure is:

✓ Patient identification of a proxy to receive verbal disclosure of health and business information.

IV. Expiration and Revocation: I understand that I may revoke this authorization in writing submitted at any time except to the extent of disclosure made on reliance of consent having occurred prior to revocation. Southern New Mexico Surgery Center, employees and officers are released from legal responsibility or liability for release of the above information to the extent indicated and authorized herein. If this authorization has not been revoked, it will expire one year from the date of my signature unless a different expiration date is stated.

Specify new date: _____

Signature_____ Date_____

Printed Name _____ Relationship to Patient _____