SOUTHERN NEW MEXICO SURGERY CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Southern NM Surgery Center to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire 365 days from the date of signature or at the date or event specified here (Expiration date/event)_____.

I further understand that I may revoke this authorization at any time by notifying, in writing, the Southern New Mexico Surgery Center facility where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written· revocation.

I understand there is a charge for photocopies and records provided on electronic media as indicated below, as permitted by law, unless copies are sent directly to another healthcare provider.

Patient Name	Last 4 of Social Security Number	Date of Birth / / MM DD YYYY	Acct #
StreetAddress City	Zip		Telephone Number

RELEASE OF THE INFORMATION FOR:

□ The following treatment dates_____ OR □ All treatment dates

INFORMATION TO BE RELEASED TO: □ Patient/Designee □ Health Care Entity □ Insurance Company □ Attorney □ OTHER_____

INDIVIDUAL/ ORGANIZATIONAL NAME		TELEPHONE #
STREET ADDRESS	CITY, STATE, ZIP	FAX #

PURPOSE OF THE USE AND/OR DISCLOSURE: □ Continued Care □ Legal □ Insurance □ Personal Use □ Other_____

COPY FORMAT: □ Paper □ CD □ Electronic □ Email Address: _____

DELIVERY METHOD: □ Fax □ Mail □ Picked up in Person on site □ Electronic

INFORMATION TO BE RELEASED: □ Complete Medical Record □ Operative Report
□ Billing Statements □ Other: _____

□ $50 Medical Record Processing Fee □ Patient Only: No charge for operative report

I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting this request. PLEASE ALLOW UP TO 30 DAYS TO PROCESS REQUEST.

_____ _____
Signature of Patient or Legal Representative (electronic signatures not acceptable) Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to Patient

The information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

PAYMENT AMOUNT: $_____ DATE RECEIVED: _____ DATE SENT: _____ INITIALS: _____