SOUTHERN NEW MEXICO
SURGERY CENTER

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

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I. Please indicate FORMAT in which you would like your medical records:

Select One: □ Paper or □ Other electronic reproduction (USB/CD/ ETC: additional cost apply)

II. Please indicate how you would like to RECIEVE your medical records:

Select One: □ In person or □ Postal Mailed or □ Email (encrypted) or □ Fax

III. I, _____, hereby voluntarily authorize the disclosure of information from my health record.

PATIENT INFORMATION

Patient Name _____ Date of Birth ____/____/____
Address _____ Patient SS# _____
City/State/Zip _____ Contact # (____) _____-_____
Fax # _____

IV. IF REQUESTOR OTHER THAN PATIENT:

Name of Organization/ Person: _____ Contact #:_____
Address: _____ Fax#: _____
City/ State/ Zip: _____

V. The purpose or need for this disclosure is:

□Personal use □Insurance □Disability □Attorney □School □Medical Care
□Research □Other (*Specify*) _____

VI. The Information to be disclosed from my health record or billing: (check all that apply)

□ Operative Report □ Billing Statements □ Other: _____

Specify the Dates of the Procedures to be released:
Single Date _____
Multiple Dates from_____to_____

VII. 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 If this authorization has not been revoked, it will expire one year from the date of my signature unless a different expiration date is stated.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: _____

VII. Reasonable cost based charge for paper copies based off of NM Administrative Code Section 16.10.17:

□ $30 1st 15 pages; $.25/page thereafter □ Patient Only: No Charge for Operative Report

VIII. SOCIAL SECUIRTY DISABILITY REQUEST ONLY: Based off of NM Administrative Code 7.1.10.8B: must be accompanied by a written verification of the application or appeal of a denial of such benefits if not then section VII cost apply.

□ $2.00/page for the first 10 single sided pages/thereafter $.20/ page

Signature_____ Date_____
Printed Name _____ Relationship to Patient _____

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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_____ Employee Initials_____