

Authorization for the Disclosure of Protected Health Information "PHI"

Patient Name: _____ Date of Birth: _____

I authorize Christus Health of Southern New Mexico to disclose the health information of the above-named individual as described below.

The type of information to be used or disclosed is as follows:

_____ Discharge Summary	_____ Radiology Report	_____ Sleep Study Results
_____ History & Physical	_____ Laboratory Exams	_____ Emergency Room Record
_____ Operative Report	_____ Stress Test Results	_____ Echocardiogram Report
_____ Pathology Report	_____ Other (explain) _____	

For service dates from _____ to _____
(Date) (Date)

_____ **(Initial)** I understand that the information released in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency (AIDS), human immunodeficiency virus (HIV) and sexual reproduction records. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Specified information is to be disclosed to the following entity or individual:

(Name of indicated entity or individual to receive protected health information)

(Address, City, State, Zip)

(Phone Number, Fax Number)

For the following purpose(s): _____

I understand that I have the right to revoke this authorization at any time and that I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire:

☐ Upon fulfillment of this request; or ☐ One year from today's date.

I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by Federal confidentiality rules.

My signature below acknowledges that I have read, understand and authorize the release of my PHI.

Print Name: _____
(If Personal Representative, include a description of authority to act for patient)

Signature: _____ **Date:** _____

State-issued photo ID is required when requesting records.

Return this **completed** form to Christus Health of Southern New Mexico's Health Information Management (HIM) Department. If you have any questions, please call 575-443-7800

For CSNM Use Only: Date that this authorization was received by CSNM: _____

Action taken _____ MRN _____

