P: 505.225.2500 | **F:** 505.225.2025
610 Broadway Blvd. N.E. , Albuquerque, NM 87102
dermatologynm.com

Authorization to Release OR Request Healthcare Information/ Medical Records

Patient's Name *(as it appear as on Driver's Licence or Photo ID)*

Last Name: ____________________ First Name: ____________________ Middle initial: ______

Date of Birth: ________ / ________ / ________

I authorize Dermatology of New Mexico, LLC to REQUEST healthcare information of the patient named above from the following entity:

Name: ____

Street Address: ____

City: ____________________ State: ____________ Zip: ____________

Phone: ____________________ Fax: ____________________

I authorize Dermatology of New Mexico, LLC to RELEASE healthcare information of the patient named above to the following entity:

Name: ____

Street Address: ____

City: ____________________ State: ____________ Zip: ____________

Phone: ____________________ Fax: ____________________

Please send copies of the following Medical Records (mark all that apply):

❏ Clinic notes ❏ Pathology report(s) ❏ Lab report(s) ❏ Other

❏ Entire Medical Record (excluding records sent to DNM by outside health providers)

❏ I request that if possible records be sent via Electronic Direct Mail

Reason for Release of Records:

❏ Continuing care ❏ Transfer of care ❏ Personal use* ❏ Insurance application* ❏ Other

**a fee may be applied (please call medical records for details)*

This authorization may include disclosure of information relating to alcohol and drug treatment, sexually transmitted disease, and mental health treatment or confidential acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) information only if I place my initials here ________

If I authorizing the release of HIV/AIDS-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 also understand the following:

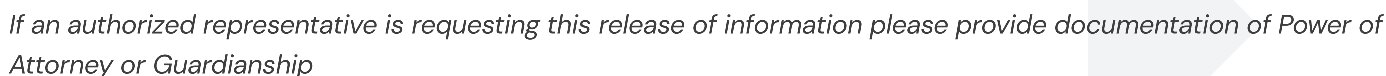
- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations.
- I understand that the healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization or not.
- I may refuse to sign this authorization.
- I may request a copy of this form.

______________________________ ______________

Patient/Guardian Signature Date

____

Expiration Date (One year from the date of request)



If an authorized representative is requesting this release of information please provide documentation of Power of Attorney or Guardianship