SOUTHWEST CARE

Authorization to Release Medical Records

This authorization DOES NOT include the release of Substance (Alcohol/Drug) Treatment

Please print legibly and note that patient and witness signatures are REQUIRED on the back of this form.

IMPORTANT NOTICE: This authorization is required by the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts, 160 and 164. It authorizes Southwest CARE Center (SCC) to disclose or release Protected Health Information (PHI) about you to ONLY those you have authorized to receive the information. Medical records processing may take up to 30 days business days.

In the event of an emergency, your protected health information will not be disclosed to your emergency contact unless you indicate below.

If you are a person with a disability and you require this authorization in an alternative format or require a special accommodation to complete this form, you may request assistance from SCC staff.

This authorization will remain effective for twelve (12) months unless otherwise noted, and may be revoked at any time upon a written notice submitted to the SCC Privacy Official.

1. Purpose for Authorization

Please explain the purpose for the release of your medical records or Protected Health Information (PHI):

☐ Continuity of Medical Care with new physician/provider, referral, insurance claims, legal

☐ Disclosure of Protected Health Information (PHI) to spouse, partner, legal representative, other: _____

☐ Emergency Contact (name):

2. Patient contact information

Patient name (First, MI, Last)	Date of birth (mm/dd/yyyy):
Any previous names held by the patient (Ex. Maiden Name):	
Patient mailing address (Street or PO Box, City, State, Zip Code):	
Preferred telephone number (Area code first):	

3. I hereby authorize records FROM: To be released TO:

Name	Name
Address	Address
City, State Zip	City, State Zip
Phone	Phone
Fax	Fax

4. Please date and initial in the boxes below to indicate what medical records you would like released.

Today's Date	Patient Initials	Please release the following records as indicated by my initials and today's date.	Date Ranges Include: mm/dd/yyyy
		My **COMPLETE** medical record to include HIV/AIDS testing and treatment; and Sexually Transmitted Diseases (STD) testing and treatment; **EXCLUDING** Behavioral Health Treatment and Genetic Testing.	
		My medical records **EXCLUDING** HIV/AIDS testing and treatment; and Sexually Transmitted Diseases (STD) testing and treatment.	
		My medical records **INCLUDING** Behavioral Health Treatment	
		My medical records **INCLUDING** Genetic Testing	

5. Preferred Method of Delivery: ☐ Fax ☐US Mail ☐Call to Pick-Up

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6. **Special Instructions and preferred method of delivery (paper/ US mail/ pick-up). Please list any specific information, special instructions, limitations or exceptions regarding these disclosures—paper record, CD Rom.**

_____

7. **Statement of understanding:**

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the SCC HIPAA Privacy Official. I understand that the revocation will not apply to information that has already been released in the 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.
- I understand that authorizing the disclosure or use of this protected health information is voluntary.
- I can refuse to sign this authorization.
- I need not sign this form to receive treatment from SCC. I understand that I may inspect or receive copies of the information to be used and/or disclosed.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the re-disclosure may not be protected by federal or state confidentiality rules.
- I have the right to limit the information disclosed.
- A signed faxed copy of this release is acceptable for the release of Protected Health Information (PHI).

8. **This authorization will expire on _____ (mm/dd/yyyy). Unless otherwise revoked, this authorization will expire (12) months from the date signed. To revoke this authorization, with the understanding the revocation will only apply to future disclosures or actions regarding your Protected Health Information and cannot cancel actions or disclosures made while the authorization was previously in effect and valid. Please submit your written request to ATTN: HIPAA Privacy Official, P.O. Box 6880 Santa Fe, NM 87502-6880 or Fax: (505) 986-3494.**

If you have questions about this form, please contact the Medical Records Department at:
Phone (505)989-8200 Ext. 2005 or Fax: (505) 986-3494.

Signature of patient or legal representative	Date (mm/dd/yyyy):
Printed name of patient or legal representative	Relationship to patient
Signature of witness:	Date (mm/dd/yyyy)

For office use only

Provider initials/log note:	Tracking number:	Date sent (mm/dd/yyyy):	Initials:
Date scanned into EMR (mm/dd/yyyy):		Scanned into EMR verified/initials:	