the Fertility Center of New Mexico

JIM THOMPSON, M.D.
201 Cedar Street SE, Suite S1-20 • Albuquerque, NM 87106
PH: 505-248-0000 • Fax: 505-842-0000
Infertility • Gynecology • Reproductive Endocrinology

Internal Use Only

MRN: _____

ROI Status: ❑ Processed ❑ Returned to Requester
❑ Encounter
❑ Chart Review ❑ Return Letter Date: _____

❑ Document(s) released in accordance with scope of patient request
Date records were provided: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instructions before completing and signing the authorization form.

Patient's Name & Birth date (Please Print) LAST, FIRST, MI

_____ _____

Are medical records filed under another name? _____ Phone Number _____

INFORMATION TO BE RELEASED *BY:*	**INFORMATION TO BE RELEASED *TO:***
_____ Organization/Person Name	_____ Organization/Person Name
_____ Street Address City, State, Zip	_____ Street Address City, State, Zip
_____ Phone Fax	_____ Phone Fax

TYPE OF MEDICAL INFORMATION REQUESTED:

❑ Complete Record (includes: Physician Orders, Annual, Chart Notes, Medication List, Treatment Plans, Labs, or X-Rays)
❑ Only Labs ❑ Medication List ❑ Hospital Dictation
❑ Self-Pay Records ❑ STD or HIV Results ❑ Mental Health or Psychiatric Conditions ❑ Substance Abuse (Drug or Alcohol)
❑ My health information relating only to the following treatment or condition: _____
❑ My health information only for the following date(s): _____
❑ Other: _____

REASON FOR REQUEST: ❑ Personal ❑ Transfer of Care ❑ Disability ❑ Insurance ❑ Legal Review ❑ Continuing Care

❑ Other (please explain): _ You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

MINORS AGE 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older).

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. I have the right to revoke or cancel this authorization, in writing, at any time. I **understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).**

UNLESS THE RECORDS ARE BEING SENT TO A PHYSICIAN OR HEALTH CARE FACILITY THAT THIS OFFICE HAS REFERRED YOU TO, THERE WILL BE A CHARGE FOR YOUR RECORDS.

This authorization expires _____ **(date or event). Authorization will expire in 90 days if not otherwise specified.**

Patient signature
-OR- _____ Date _____
Parent or Legal Guardian/ Relationship to patient, if other than patient (You may be required to provide legal documentation as proof for power of attorney or guardianship)

_____

Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

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NMFertility.com

INSTRUCTIONS & IMPORTANT INFORMATION

Please read all information and instructions before completing and signing the authorization form.

Many patients ask The Fertility Center of New Mexico to communicate by fax. It is the policy of The Fertility Center to use fax transmissions when necessary for treatment, payment or healthcare operations to other Physicians or Healthcare Facilities only. The Fertility Center will not fax medical records to any personal or other business fax number that has not affiliated with an established Healthcare Entity or Facility.

By providing The Fertility Center of New Mexico with a fax telephone number, you are consenting to the use of that number for communicating by fax to another Physician or Healthcare Facility only.

PATIENT RIGHTS

You have the right to revoke or cancel this authorization, in writing, at any time.

REQUEST PROCESSING NOTICE

Please allow ten business days to process your records request. Processing time does not account for mailed records.

FEES

If you are referred to another provider (by this office), any requested records will be sent to that provider at no charge. For any other circumstances, the fee is $30.00 for the first 15 pages and $.25 for each page thereafter. If you need records for multiple providers, please obtain a copy of your records and distribute to your providers as needed.

CANCELLATION NOTICE

According to the Uniform Health Information Act for the State of New Mexico, records shall be released within fifteen days after receipt of a signed, dated release form. Since records are usually handled within 2 – 3 days after receipt, Fertility Center of NM will not be held responsible for any release of medical information accomplished before receipt of a written notice of cancellation. Revocation takes place from the date of receipt of written request in the Health Information Management department.

Instructions for Canceling a Request:

1. You must provide a written request to the Health Information Management department asking for revocation/cancellation of the original record release.
2. We need to have your complete name, date-of-birth, telephone number (home/work) and the name of the person/agency that you authorized to receive the medical information.
3. After receipt of the notice by the Health Information Management department, telephone confirmation will acknowledge your withdrawal of authorization.
4. If the release has been accomplished, you will be notified by a representative of the Health Information staff. The release will be revoked for any further disclosure.
5. If you have any questions concerning the cancellation process, call the Health Information Management Medical Record Department (505) 248-0000.