Lovelace Medical Group
6701 Jefferson NE
Albuquerque, NM 87109

RELEASE OF INFORMATION AUTHORIZATION/REQUEST

ROID0021 (Rev 08/04/20)

We are not able to process incomplete authorizations. To prevent delays in processing this request please complete all sections of the authorization. Incomplete authorizations will be returned.

Patient Information	Patient Name		
	Address		
	City/State/Zip		
	Phone #		
	Date of Birth		
RELEASING Facility	Facility Name	Lovelace Medical Group	***If you need information from another Lovelace facility, please specify which facility below:***
	Address	6701 Jefferson NE	
	City/State/Zip	Albuquerque, NM 87109	
	Phone #	505-727-8197	
	Fax #	505-727-9501 - Routine	
Receiving Facility/ Individual(s)	Name		
	Address		
	City/State/Zip		
	Phone #		
	Fax #		

Information to be: ❑ Mailed to above address ❑ Picked up ❑ Call # above when ready for pickup ❑ Fax to above #

The requested information will be used for the following purpose(s):

❑ **Continuity of Care** ❑ **Disability Determination** ❑ **Insurance** ❑ **Legal** ❑ **Personal Use**

Date(s) of Service Requested: From_____ **To** _____

List specific description of Information to be released				
	❑ Billing Records	❑ Facesheet	❑ Medication Records	❑ Progress Notes
	❑ Consultation	❑ History & Physical	❑ Nursing Records	❑ Therapy Records
	❑ Discharge Summary	❑ X-Ray/Imaging Reports	❑ Operative Report	❑ All Records
	❑ EKG's	❑ X-Ray/Imaging Films/CD	❑ Pathology Report	❑ Other:
	❑ Emergency Records	❑ Laboratory	❑ Physician Orders	

Behavioral Health Records, HIV, STD	*If these types of records are being requested, patient must sign below authorizing release.* ❑ Behavioral Health Records ❑ HIV Records ❑ STD Records ❑ Alcohol/Drug Treatment Records Patient or Legal Representative Signature Required:_____
Request for Electronic Records *(Lovelace Medical Center, Westside & Women's only)*	❑ I would like to request an electronic copy of my discharge instructions. ❑ I would like to request an electronic copy of my patient health information as defined here (including test results, problems, medications, allergies, discharge summary, and procedures). I understand the facility has three business days to provide this copy.

- The person/organization authorized to use/disclose the information will receive compensation for doing so.
  ❑ Yes ❑ No
- I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for our coverage of services, or ability to obtain treatment, except as provided under the NOTES listed at the bottom of this form.
- I understand that I may revoke this authorization at any time by notifying the facility releasing records in writing to the Lovelace Health System, except to the extent that; action has been taken in reliance on this authorization; or if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
- This authorization shall be in force and effective for one year from the date of signing or until_____, at which time this authorization to disclose this protected health information expires.

_____	_____
Signature of patient or patient's legal representative	Date
_____	_____
Printed name of patient or patient's legal representative	Relationship to patient or representative's authority to act for the patient, if applicable

NOTE: If the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, Lovelace Health System reserves the right to deny treatment associated with such research.

NOTE: If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Lovelace Health System reserves the right to deny that health care.

NOTE: Lovelace Health System recognizes a patient's rights under HIPPA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

A copy of this signed form will be provided to the patient.

For Office Use Only:

ID Verified ❑ Yes ❑ No
Type of ID P'd ❑ Driver's License ❑ Military ❑ School ❑ Other_____

Verified by_____ _____
Employee Name Date