



www.shodenwilliams.com

883 Lead Ave, SE, Suite A
Albuquerque, NM 87102
Main - 505-247-8820 | Fax - 505-246-9421

INTERNAL USE ONLY:	MRN: _____
	ROI Status: <input type="checkbox"/> Processed <input type="checkbox"/> Returned to Requester <input type="checkbox"/> Encounter
	<input type="checkbox"/> Chart Review <input type="checkbox"/> Return Letter Date: _____
	<input type="checkbox"/> 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:
<input type="checkbox"/> Southwest Women's Health, PA <input type="checkbox"/> _____ <small>Organization/Person Name</small> <hr/> <small>Street Address</small> <small>City, State, Zip</small> <hr/> <small>Phone</small> <small>Fax</small>	<input type="checkbox"/> Southwest Women's Health, PA <input type="checkbox"/> _____ <small>Organization/Person Name</small> <hr/> <small>Street Address</small> <small>City, State, Zip</small> <hr/> <small>Phone</small> <small>Fax</small>

TYPE OF MEDICAL INFORMATION REQUESTED:

- Last 2 years of Gynecology Records (includes: Physician Orders, Annual, Chart Notes, Medication List, Treatment Plans, Labs)
- Only Labs Medication List
- Self-Pay Records STD or HIV Results
- 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).

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.

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

Patient signature _____ Date _____

Parent or Legal Guardian _____ Date _____

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.

INSTRUCTIONS & IMPORTANT INFORMATION

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

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.

Many patients ask Southwest Women's Health, PA to communicate by fax. It is the policy of Southwest Women's Health, PA to use fax transmissions when necessary for treatment, payment or healthcare operations to other Physicians or Healthcare Facilities only. Southwest Women's Health, PA 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 Southwest Women's Health, PA 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 no account for mailed records.

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, Southwest Women's Health, PA 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) 247-8820.