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

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:*
☒ Southwest Women's Health, PA	❑ Southwest Women's Health, PA
❑ ________ Organization/Person Name	☒ SOUTHWEST WOMEN'S ONCOLOGY Organization/Person Name
883 LEAD AVENUE SE, SUITE A , ALBUQUERQUE, NM 87102 Street Address City, State, Zip	201 CEDAR STREET SE, SUITE 304, ALBUQUERQUE, NM 87106 Street Address City, State, Zip
(505) 247-8820 (505)246-9421 Phone Fax	(505) 873-7813 (505) 843-6947 Phone Fax

TYPE OF MEDICAL INFORMATION REQUESTED:

❑ Complete Gynecology Record (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.