ROOSEVELT GENERAL HOSPITAL
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(Including HIV Test Results; Alcohol / Drug Abuse Records; and Mental Health / Developmental Disabilities Records)

Date: _____

Patient's Full Name: _____

Date of Birth: _____ Social Security #: _____

Mailing Address: _____ Admission: _____

City / State / Zip: _____ Medical Record #: _____

Purpose For Release of Records: _____

I specifically request that the following information be released: _____

_____Date of admission for which records are requested: _____

_____ I, _____ (hereafter "Releaser"), hereby authorize Roosevelt General Hospital and its affiliates, to release any and all of my medical records including, but not limited to the following: HIV tests / test results; Alcohol / Drug Abuse Records; and Mental Health / Developmental Disabilities Records. I authorize the records to be released for the purpose stated above. I understand that this consent to release records is not a condition for treatment. The records are to be released to:

In addition, the information may be released to my third-payor(s) and their agents or representatives for insurance purposes, review of services, or receipt of benefits.

Unless otherwise limited above, this authority to release applies to any document, records or information relative to Releaser's past, present or future condition.

IN ADDITION, RELEASER SPECIFICALLY ACKNOWLEDGES THAT SUCH RECORDS MAY INCLUDE AND / OR CONTAIN REFERENCE TO ANY OR ALL THE FOLLOWING SBJECTS AND RELEASOR, BY AFFIXING RELEASOR'S SIGNATURE HERETO, HEREBY DIRECTS THAT ALL OF THE FOLLOWING MATERIALS ALSO BE RELEASED AS SPECIFIED HEREIN.

A. Any and all of Releaser's medical records including but not limited to reports / documentary materials / tangible materials, which relate in any way to DRUG / ALCOHOL / SUBSTANCE ABUSE, including any information which can be protected by federal law pursuant to 42 CRF Part 2.

This information which relates to this section is to be released pursuant to 42 CFR Part 2, Subpart C. Such information, when released, will be accompanied by the following statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you 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. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Roosevelt General Hospital
42121 US Hwy 70 • Portales, NM 88130
P. 575.359.1800 • F. 575.356.7116

B. Any and all of Releaser's medical records including but not limited to reports / documentary materials / tangible materials, which relate in any way to EMOTIONAL / MENTAL HEALTH / DEVELOPMENTAL DISABILITIES AND / OR PSYCHIATRIC CONDITIONS, including any which may be protected by state law and which may be disclosed pursuant to 43-1-19 NMSA (1978) or 32A-6-15 NMSA (1978).

To the extent that this consent to release information applies to this section, I understand that I have a right to access confidential information about myself, and that I have a right to copy any information and to submit clarifying or correction statements and other documentation of reasonable length for inclusion with the confidential information (as authorized by 42-1-19 et seq. NMSA, 1978).

C. Any and all of Releaser's medical records including but not limited to reports / documentary materials / tangible materials, which relate in any way to HUMAN IMMUNE DEFICIENCY VIRUS (HIV) INFECTION / TESTING AND / OR TO ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), including any information which may be protected by state law and which may be disclosed pursuant to 24-2B-1 NMSA (1978) et seq.

This information is to be released pursuant to Section 24-2B-7 NMSA (1978), and this authorization to release information to the above-named recipient of the information shall be accompanied by a disclosure substantially similar to the following:

This information has been disclosed to from records whose confidentiality is protected by stat law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A person who makes an unauthorized disclosure of this information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine or not more than five hundred dollars ($500), or both.

I understand the above statement relative to this section informs the recipient of the administration of an HIV test and / or of HIV test results and, except as provided in the New Mexico Human Immunodeficiency Virus Test Act (the "Act"), it is against the law to further disclose the results to any other person. I realize that Roosevelt General Hospital and its affiliates or my physician have no other legal obligation and / or ability to limit disclosure of such test result information by the recipient of the information.

I also understand that this consent is subject to revocation in writing at any time, except to the extent that the facility which has been directed to make a disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate in (6) months from the date of my signature.

I certify that I have read this form or that its contents have been read and explained to me; I understand its contents; and all blanks or statements requiring insertions or completion were filled in and all items not applicable were stricken before I signed. I hereby release the physicians who provided my hospital care, Roosevelt General Hospital and its affiliates, its officers, directors, employees and agents, form any and all liability and claims of any nature that may arise form the release of information contained in my medical record.

Signature: _____ Date/Time: _____
Patient / or Patient's Legally Authorized Representative

_____
Relationship to Patient

Signature: _____ Date/Time: _____
Witness