RGH Clinic
42121 US Highway 70
Portales, NM 88130
(575) 356-6652
(575) 359-6827

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient: SSN: DOB: Patient Number:
Address: Phone:

Records release from (required):

Name:

Address:

City, State & Zip:

Phone:

Fax:

Records to be release to (required):

Name:

Address:

City State & Zip:

Phone:

Fax:

Information to be released:

_____ Entire Health Record Date Range: _____

_____ Immunization Records Only

_____ Specific Date(s) of Treatment: _____

_____ Hospital Records

_____ Other: _____

I am requesting that this protected information be released for the following reason:

_____ This request is being made by the patient.

_____ This request is being made because I am transferring my care to another provider or specialist.

_____ I also authorize the release of information regarding assessment, diagnosis and treatment of alcohol and/or substance abuse.

_____ I also authorize the release of information regarding diagnosis and/or treatment of AIDS or HIV.

_____ I also authorize the release of information regarding diagnosis and/or treatment of mental or behavioral health

I understand that I have the right ot revoke this authorization, in writing, at any time by sending a written notification to RGH Clinic, Attn: Medical Records Clerks at the above address.

I hereby authorize RGH Clinic to disclose my medical information as requested. Information used or disclosed by this authorizaiton may be subject to subsequesnt disclosure by the recipient and no longer be protected by this rule.

This release expires six months from the signed date below.

THERE MAY BE A SERVICE CHARGE FOR THE COPYING OF RECORDS IN EXCESS OF 20 PAGES

Patient Name:

Patient Signature:_____ Date:

Legal Representative:_____ Date:

Records Copied By:_____ Date: