RELEASE OF PATIENT INFORMATION

Patient Name: ______________________________ DOB: _________________________________

I hereby authorize the release of medical information obtained in the Diagnosis and Treatment:

From: Albuquerque Center for Rheumatology
1617 University Blvd. NE
Albuquerque, NM 87102
Phone: (505)341-4148 Fax: (505)345-9914

To: __________________________________
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The disclosure of information is for the purpose of treatment.

- ○ **Office notes from date** _____________________to_____________________
- ○ **Summary of all records**

1. This authorization is voluntary, and I may refuse to agree to its terms without affecting any of my rights to receive healthcare at the Practice.
2. This authorization may be revoked at any time by notifying the Practice in writing at the above address to the attention of “Privacy Officer”.
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. The information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and thus this information will no longer be protected by federal privacy regulations.
5. My health care and payment for my health care will not be affected if I do not sign this form.
6. I may see and copy the information described in this form, if I ask for it, and would be able to obtain a copy of this form after I have signed it.
7. This form was filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.
8. This authorization is valid as of the date I have signed below and shall remain valid for a period of one year.
9. I understand that this authorization may include the release of information relating to communicable diseases such as MRSA, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral, developmental disabilities or mental health services or conditions. It may include the release of information pertaining to the treatment for alcohol and drug use.
   Initials of patient ____________

___________________________________	___________	____________________________
Patient Signature	**Date**	**Witness**