AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

SANTO DOMINGO PUEBLO HEALTH CENTER
PO BOX 340 Santo Domingo Pueblo, N.M. 87052 ☙ Phone: (505) 465-3063 ☙ Fax: (505) 465-1178

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ Medical Record Number: _____

Address: _____ State/Zip _____ Ph #: _____

I hereby voluntarily authorize the following organization to release information as stated below from my health record:

INFORMATION TO BE RELEASED FROM: (check appropriate box)

☐ SANTO DOMINGO PUEBLO HEALTH CENTER, PO BOX 340, Santo Domingo Pueblo, NM 87052 OR

☐ NAME OF PERSON, FACILITY OR ORGANIZATION: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED TO:

☐ SANTO DOMINGO PUEBLO HEALTH CENTER, PO BOX 340, Santo Domingo Pueblo, NM 87052 OR

☐ NAME OF PERSON, FACILITY OR ORGANIZATION: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐Further Medical Care ☐Attorney ☐School ☐Personal Use ☐Insurance ☐Disability ☐Other: _____

INFORMATION TO BE RELEASED:

☐Only Information related to: _____

☐Records for Dates of Service from : _____ to: _____

SENSITIVE INFORMATION:

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐Behavioral Health Treatment ☐Sexually Transmitted Diseases ☐AIDS/HIV Treatment ☐Alcohol/Drug Abuse Treatment/Referral

SIGNATURE

I understand that

Authorizing the disclosure of this healthcare information is voluntary and that Santo Domingo Pueblo Health Center will not condition treatment or eligibility for care on my providing this authorization except if such care is 1. research related or 2. provided solely for the purpose of creating Protected Health Information for disclosure to a third party. I can cancel this authorization at any time by writing to the Health Information Management Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PARTY: _____ DATE: _____

RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT: _____ DATE: _____

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor. (5 USC 552a (i)(3).