



502 ELM ST. NE
Albuquerque, NM 87102
Ph: 505 841-1000
Fax: 505-843-2593

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize use or disclosure of the health information as described below.

Patient name		Date of birth	Social Security number	
Address (street, city, state, zip code)			Telephone number	
The following individual or organization is authorized to make the disclosure: <input type="checkbox"/> New Mexico Heart Institute <input type="checkbox"/> other (please specify) _____				
This information may be disclosed to and used by the following individual or organization: <input type="checkbox"/> New Mexico Heart Institute <input type="checkbox"/> other (please specify) _____				
Treatment dates:		Purpose of request: <input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Attorney Use <input type="checkbox"/> Personal Use <input type="checkbox"/> Other:		
The following information is to be disclosed: <i>(Please check one box for each item.)</i> yes no <input type="checkbox"/> <input type="checkbox"/>Physician notes <input type="checkbox"/> <input type="checkbox"/>Lab results <input type="checkbox"/> <input type="checkbox"/>X-ray reports <input type="checkbox"/> <input type="checkbox"/>CT or MRI scans <input type="checkbox"/> <input type="checkbox"/>Cardiac studies <input type="checkbox"/> <input type="checkbox"/>Complete record <input type="checkbox"/> <input type="checkbox"/>Other _____				
Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS), infection with the Human Immunodeficiency Virus (HIV), or viral hepatitis, including Hep B and Hep C. It may also include information about behavioral or mental health services, developmental disability, or treatment for alcohol or drug abuse.				
Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules. However, most healthcare providers and health insurance companies must comply with federal privacy regulations.				
Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be submitted in writing to the Office Manager, New Mexico Heart Institute, at the address shown above. And I understand that the revocation will not apply to information already released based on this authorization.				
Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign it to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed.				
Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: <i>(If I do not specify an expiration date, event or condition, this authorization will expire in one year.)</i>				
Signature of patient or legal representative			Date	
If signed by legal representative, relationship to patient:			ID Verified yes no <input type="checkbox"/> <input type="checkbox"/>	Verified by: