AUTHORIZATION for RELEASE of HEALTH INFORMATION

Name of Patient: _____ Date of Birth:_____ ID Number:_____

Person/Organization **PROVIDING** information:

_____

_____

_____

_____

Person/Organization **RECEIVING** the information:

_____

_____

_____

_____

Describe the information to be released. Include dates of service and type of service:_____

_____

_____

Describe the purpose of this request._____

- I understand that medical records described above may include sensitive information related to Workers Compensation, HIV/AIDS infection, psychological diagnosis and treatment, or drug and alcohol abuse information
- The Campus Health Center will not condition my treatment, payment, or enrollment in a health plan on whether I provide authorization for the above request
- This authorization shall become effective immediately and will expire on the following date, event, or condition _____ or in six months from the date signed
- I understand that I will receive a copy of this form after I sign it. I may see and request a copy of the information described on this form if I ask for it. I agree to pay any fees associated with copying of records. I also understand that any review of original medical records will be supervised
- I understand I have the right to revoke this authorization in writing received at the address below. I understand that the revocation will not apply to information that has already been released in response to this authorization
- I understand that the authorized health information may be electronically communicated

YOUR AUTHORIZATION IS VOLUNTARY YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Patient *or* Legal Representative Signature: _____ Date _____

Printed name of patient's legal representative: _____

Relationship to the patient: _____

NEW MEXICO STATE UNIVERSITY Campus Health Center, P.O. Box 30001, MSC 3529, Las Cruces, NM 88003

Instructions for the Completion of Authorization for Release of Health Information

The authorization may be printed and used for your convenience. This form may also be obtained at the Front Desk of the NMSU Campus Health Center. A patient may use this form to request that their Campus Health Center records be sent to another healthcare provider, or for other purposes authorized by the patient.

Please be careful to read and complete all sections of this form

Copying charges are associated with copying of records (generally $17) which are released to the patient or other non-health care entity. No charges are associated with copying of records which are mailed directly to another healthcare facility or practitioner's office.

Mail or bring the completed form to:

NMSU Campus Health Center
MSC 3529, PO Box 30001
Las Cruces, NM 88003-8001

If you have any questions regarding the form, obtaining medical records, or for clarification on associated charges, please call 575-646-1512.