

Perinatal Associates

of NEW MEXICO



Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide all information requested may invalidate this Authorization.

PATIENTS NAME _____ DOB _____

I hereby authorize:

Perinatal Associates of NM _____

ADDRESS 201 Cedar ST SE _____

CITY Albuquerque _____ STATE NM _____ ZIP 87106 _____

PHONE (505) 764-9535 _____ FAX (505) 843-9646 _____

To release to:

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

The following information to be Released: (Check the appropriate box)

A. **Routine Record Sets:** (office visit, diagnostic test results, problem list, medications list/allergies, immunizations) Dates of service from _____ to _____

Only the following records or types of health information _____
(Including any dates)

B. I specifically authorize release of the following information (check as appropriate):

Alcohol/drug treatment information

HIV test results

Copies of ultrasound Images
from _____ to _____

Mental health treatment information¹

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE of requested use or discloser: Patient Request Other

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

if signed by someone other than the patient, please state your relationship _____

WITNESS _____ DATE _____

¹ If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.