Santa Fe Ob/Gyn and Dr. Lynore Martinez
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AUTHORIZATION TO USE OR DISCLOSE PROTECTIVE HEALTH INFORMATION

Patient Name:
_____
(Last) (First) (Middle) (Maiden Name)
Current Address:
_____
(Street) (Apartment #)
_____
(City) (State) (Zip)
Telephone #: (_____) _____ (_____)_____
(Home) (Work)
Social Security #: _____-_____-_____ Date of Birth:_____/_____/_____

Recipient: Name and Address of Company, doctor or individual to whom the information is to be disclosed:

☐ Same as above
Name of Organization/Individual:
_____
Address:
_____
(Street) (Apartment)
_____
(City) (State) (Zip)
Phone: (_____) _____ Cell: (_____) _____

How would you like us to get you the records?

- ☐ I will pick up the records from the office
- ☐ Mail the records via regular mail

Information to be disclosed:

(Specifically describe the information to be disclose, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc,)
Date range requested: From: _____ To: _____
☐ Office notes ☐ Pap smears ☐ Biopsies ☐ Colposcopy ☐ Office procedures
☐ Lab tests ☐ Surgeries ☐ Radiological reports
☐ Others (specify on line below)
_____

Under New Mexico State Law, the following Protective Health Information requires additional authorization. Please check the appropriate box(s) if you are requesting the disclosure of any of the items.
☐ Genetic Results ☐ Substance/Alcohol Abuse Records ☐ Mental Health Records
☐ Sexual transmitted diseases (STD)

Use or disclosure of Protective Healthcare Information (check all that apply):

□ I am **transferring** from the practice because of □ Relocation □ Insurance change
□ Hospital □ Other (specify on line below)

_____

□ I am **not transferring** from the practice but need my records for □ Another physician
□ Other _____

Term: This authorization will remain in effect from the date on this authorization until Santa Fe OB/GYN fulfills the request.

AUTHORIZATION:

- I understand that once Santa Fe OB/GYN discloses my health information to the recipient in accordance with the terms and conditions of this authorization, Santa Fe OB/GYN cannot guarantee that the recipient will not re-disclose my health information to a third party.
- Any such third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Santa Fe OB/GYN's treatment of me; except, however, if my treatment at
- Santa Fe OB/GYN is for the sole purpose of creating PHI for disclosure to the recipient identified in this authorization, in which case Santa Fe OB/GYN may refuse to treat me if I do not sign this authorization.
- I understand that this authorization will remain in effect until the term of the authorization expires or I provide written notice of revocation to the Privacy Officer at the address listed below. The revocation will be effective immediately upon Santa Fe OB/GYN's receipt of my written notice, except that the revocation will not have any effect on any action taken by Santa Fe OB/GYN in reliance on this authorization before it receives my written notice of revocation.
- I have been advised that the State of New Mexico provides that physicians may impose a reasonable charge for copies of a patient's records, $15 for the first 15 pages and 10 cents for each additional page. The cost of postage is additional.
- I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize Santa Fe OB/GYN to use or disclose my health information in the manner described above.

Signature of Patient or Personal Representative:

_____ Date: _____

Name and Authority of the Personal Representative:

_____