



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT

NAME: _____
Last First Middle

DATE OF BIRTH: _____ MEDICAL RECORD # _____

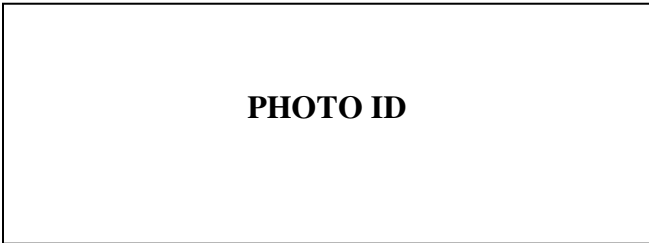
Address: _____

I authorize and request Los Alamos Medical Center and the physician(s) who attended me to access my records for the purpose of review and examination. I authorize and request Los Alamos Medical Center to provide copies of my medical records as specified below and that said documentation is furnished to:

Name: _____

Address: _____ Fax # _____

- Entire Medical Record
Radiology Report(s)
History & Physical
Consultation
Physical Therapy
Other
Lab Report(s)
Pathology Report(s)
Discharge Summary
Radiology CD
Radiology Films



The foregoing is subject to such limitations as indicated below:

- 1. Confined to records regarding admission and/or treatment for the following condition or injury:
2. Date of Service(s):
3. At (facility):
4. Confined to the following specified information:
5. For the purpose of:

This authorization is valid for three (3) months unless otherwise specified. Expiration date of this authorization:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that this authorization also applies to records about me containing information about HIV, AIDS, venereal disease, or mental disorders. In accordance with federal regulation 42 CFR part 2: I also understand that release of any and all alcohol and/or drug abuse treatment that such information cannot be released without my specific authorization, except in special circumstances. Therapists notes related to mental disorders will also require a specific authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulation, the released information may no longer be protected by federal privacy regulations.

I understand that I have the right to revoke this authorization at any time.

I hereby release Los Alamos Medical Center from all legal responsibility and liability that may arise from the authorization given above.

Signature _____ Date _____

If signed by a personal representative, please state relationship and authority to do so: _____

ID Checked _____ Copy of ID Attached

Request Completed by: _____ Date Completed: _____