*Schreiber Family Medicine, LLC * (575) 751-7430 / 751-7059 fax*

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION (ADULT)

(There is a $5 charge for 5-20 pages, $10 for 21-40 pages, and $5 for each additional 20 pages that must be paid upon receipt of the records.)

Phone _____

I, _____, authorize _____ Fax _____

to use and/or disclose my health information as identified below **[name and address of recipient]**

TO: _____

ADDRESS: _____.

for the following purpose(s): _____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____ Please send the entire medical record (all information) to the above named recipient.

_____ All hospital records (including nursing records & progress notes)
_____ Transcribed hospital reports
_____ Medical records needed for continuity of care
_____ Most recent five-year history
_____ Emergency and urgent care records
_____ Other _____

_____ Clinician office chart notes
_____ Dental records
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Billing statements

***** The following items must be initialed to be included in the use or disclosure of other health information:

_____ *HIV/AIDS related health information and/or records
_____ *Mental health information and/or records
_____ *Genetic testing information and/or records
_____ *Drug/alcohol diagnosis, treatment, and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.) _____
_____

_____ ***Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to **Schreiber Family Medicine, LLC, attention: Medical Records.** Unless revoked earlier, this authorization will expire 180 days from the date of signing. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____ _____
Signature of Individual or Individual's Legal Representative | Birthdate | Today's Date

_____ _____
Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Individual

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.)