high desert pediatrics

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Albuquerque, NM 87122

T (505) 255-1866
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Release of Medical Record Authorization

Date of Request: _____ **Date Needed:** _____

Name: _____ **Date of Birth:** _____/_____/_____

Address:

_____

_____

City: _____ **State:** _____

Zip Code: _____

SSN: _____ **Phone #:** _____

I authorize my medical health information be: ☐ **Obtained From** ☐ **Released To**

Name of Provider/Facility:

_____

Address: _____ **City/State/Zip:** _____

Phone #: (_____)_____ **Fax #:** (_____)_____

PURPOSE FOR THIS REQUEST: ☐ **Transfer of Care** ☐ **Healthcare** ☐ **Insurance** ☐ **Legal** ☐ **Personal** ☐ **Other:** _____

TYPE OF RECORDS REQUESTED: SPECIFY ILLNESS/INJURY:

_____

TREATMENT PERIOD: **From:** (Month/Year) _____ **To:** (Month/Year) _____

CHECK ALL THAT APPLY:

☐ **All Records** ☐ **History/Physical** ☐ **Lab Results** ☐ **Vaccine Records** ☐ **Any Radiology**
☐ **Procedure Report** ☐ **Medication List** ☐ **Other:**

AUTHORIZATION VALID FOR: ☐ **This request only** ☐ **One year from the date of this authorization**

I understand that:

- My right to healthcare is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person/facility receiving this information is not a healthcare or insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical Records are faxed in cases of medical necessity

Signature of Patient or Parent/Guardian:

_____