New Mexico Cancer Care Associates

Authorization for Release of Medical Information

I hereby authorize New Mexico Cancer Care Associates to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire 365 days from the date of signature **or** at the date or the event specified here _____ (expiration date/event).

I further understand that I may revoke this authorization at any time by notifying, in writing, the New Mexico Cancer Care Associates facility where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand there is a charge for photocopies and records provided on electronic media, as permitted by New Mexico law, unless copies are sent directly to another health care provider.

Patient Name		Last 4 of SSN	Date of Birth	Acct #	MRN
Street Address	City, State		Zip	Telephone Number	

Please release information from these health care facilities: _____

Please release the following information for these treatments: _____

The information will be released to:

New Mexico Cancer Care Associates

490-A West Zia Rd, Santa Fe NM 87505 Phone: 505-216-6643 Email: NMCCA-INFO@nmcancercare.com

Purpose of the use and/or disclosure: ☐ Continued Care ☐ Legal ☐ Insurance ☐ Personal Use ☐ Other

Record copy format: ☐ Paper ☐ CD ☐ Electronic **Record copy delivery:** ☐ Pick-up ☐ Mail ☐ Fax to health care office

Information to be Released:

Include this information if applicable: _____ Alcohol/Drugs _____ HIV/AIDS _____ Mental Health
(PT Initials) (PT Initials) (PT Initials)

☐ Consult/Clinic Notes ☐ Radiology Scan ☐ Radiology Reports ☐ **Chemo Orders**

☐ Discharge summary ☐ Medications ☐ Laboratory results ☐ **Scheduled**

☐ Operative Notes ☐ RX, Prescription orders (last 120 days) ☐ **Signed**

☐ Other: _____

I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting this request.

_____ _____

Signature of Patient or Legal Representative Date of Signature

_____ _____

Printed Name of Patient or Legal Representative Relationship to Patient