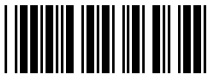


ROI

INFORMATION USE OR DISCLOSURE AUTHORIZATION

ROID0000 (Rev 03/12)

Patient Name: ____________________ Birth date: ___/___/___ MR#: ____________________

Social Security Number: ____________________

I authorize Lovelace to release health information from the following:

☐ **LOVELACE MEDICAL CENTER-GIBSON**
Hospital Records only
5400 Gibson Blvd SE *Albuquerque, NM 87108
*Phone (505) 727-8109 *Fax (505) 727-7511*

☐ **LOVELACE WESTSIDE HOSPITAL**
Formerly St. Joseph West Mesa Hospital
10501 Golf Course Rd NW *Albuquerque, NM 87114
*Phone (505) 727-2080 *Fax (505) 727-2084*

☐ **LOVELACE MEDICAL CENTER-DOWNTOWN**
Formerly St. Joseph Medical Center, ARMC
601 Dr. Martin Luther King Blvd NE * Albuquerque, NM 87102
*Phone (505) 727-8109 * Fax (505) 727- 7511*

☐ **LOVELACE WOMEN'S HOSPITAL**
Formerly NE Heights General, St. Joseph NE Heights Hospital
4701 Montgomery Blvd NE * Albuquerque, NM 87109
*Phone (505) 727-7840 *Fax (505) 727-7884*

☐ **LOVELACE REHABILITATION HOSPITAL**
(formerly Rehabilitation Hospital of New Mexico)
505 Elm St NE * Albuquerque, NM 87102
*Phone (505) 727-4719 *Fax (505) 727-4846*

☐ **HEART HOSPITAL OF NEW MEXICO**
@ LOVELACE MEDICAL CENTER
504 Elm St NE * Albuquerque, NM 87102

By Initialing the following, I request the specific type of information be released:

__ Any and all medical records / laboratory / radiology / diagnostic test, for time period: __________ to __________

__ Any and all medical records / laboratory tests which relate in any way to Behavioral Health / emotional / psychiatric history or condition for the time period __________ to __________

__ Any and all medical records / laboratory test which relate in any way to drug / alcohol / substance abuse treatment or history for time period __________ to __________

__ Any and all medical records / laboratory test which relate to the Human Immune Deficiency Virus (HIV) infection / testing and / or to Acquired Immune Deficiency Syndrome (AIDS) treatment.

__ Pharmacy profile

__ Photos, video tapes, Digital or other images related to ____________________

__ Billing information for time period: __________ to __________

__ Billing information for time period:

__ I would like to request an electronic copy of my discharge instructions

__ I would like to request an electronic copy of my patient health information as defined here (including diagnostic test results, problems, medications, allergies, discharge summary, and procedures). *I understand that the facility has three business days to provide this copy.*

Other *(Please specify)* ____________________

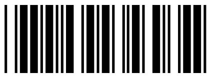
The information being disclosed is for the purpose of:

☐ Continuing Medical Care ☐ Disability Determination ☐ Underwriting
☐ Insurance Claim ☐ Legal Claim ☐ Tax Purposes
☐ Workers Comp (date of accident / onset of symptoms): ___/___/___ Date of subsequent treatment: ___/___/___
Other (please specify): ____________________

Information to be released to:
Name: ____________________ Address: ____________________
City: ____________________ State: __________ Zip Code: __________

Information to be: ☐ Mailed to the above address ☐ Picked up - date: ___/___/___
☐ Faxed to: __________ ☐ Phone to: __________

Patient telephone #: ____________________ **Patient informed of fee:** ☐ Yes ☐ No



ROI

This authorization shall be in force and effective for one year from the date of signing or until ____/____/____ at which time this authorization to disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the facility releasing the information.

I understand that in the event Lovelace has disclosed information pursuant to this request prior to a subsequent revocation of the authorization by me, Lovelace will not be held responsible for such disclosure.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Lovelace will not condition any treatment, payment, or enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).

Authorized signature: ______________________________ Date: ____/____/____

☐ Patient

☐ Authorized representative -description of authority: ______________________________

When completed, PLEASE RETURN TO MEDICAL RECORDS AT THE ADDRESS CHECKED ABOVE

INTERNAL USE ONLY

Provider Signature *(when applicable):* ______________________________

Identification verified: ☐ **No** ☐ **Yes - by:** ______________________________

I have received______________________ as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

Employee signature: ______________________________ **Printed name:** ______________________________

Date: ____/____/____

INCLUDE THE FOLLOWING STATEMENT WITH ANY AUTHORIZED DISCLOSURE:

FOR THE RECIPIENT OF THE INFORMATION:

If any of these records authorized by the patient and received by you contain information regarding alcohol or drug abuse treatment, it is protected by federal confidentiality rules (42 CFR Part 2).

The federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient