Laguna Community Health Center
P.O. Box 1407, Laguna, New Mexico 87026
(505) 431-0711, www.lagunahealthcare.org

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

1. Person(s) or Organization to whom disclosure is to be made:

Patient's Name:	Date of Birth:
Previous Name:	Last 4 Digits of Social Security #:
I request and authorize _____ to release healthcare information of the patient named above to:	**Laguna Community Health Center** **Attn: Medical Records Department** **PO Box 1407** **Laguna, NM 87026**

2. Specify type of information to be disclosed**

Date: _____ Date Through: _____

☐ Complete Copy (Charges May Apply)	☐ Pertinent Copy (Dictated reports/diagnostic tests)
☐ Labs	☐ Operative Reports
☐ Radiology/ X-Ray	☐ Emergency Reports
☐ Cardiology	☐ Discharge Summary
☐ Nuclear Medicine	☐ Other (treatment notes, diagnosis, etc)

3. The purpose and need for such disclosure, if requested by a person other than the patient or authorized representative:

☐ Continuation of Treatment of Health Care	☐ Insurance Investigation
☐ Vocational Rehabilitation	☐ Social Service Referral
☐ Disability Determination	☐ Billing Information

Other (Specify)_____

4. Information is to be:

☐ Mailed	☐ Electronic Access Employee	☐ Faxed (Doctor's Office/Hospitals Only
☐ Picked Up	☐ Electronic Access LCHC record	

If pick-up is checked, by whom (name): _____

(If someone other than patient will pick-up, include letter of authorization signed by patient or authorized representative.)

5. **Sexually Transmitted Disease (STD) includes but is not limited to herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.**

☐ Yes ☐ No	I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Patient Signature: _____ Date: _____

6. **Specify type of Substance Use Patient Records to be disclosed:**

   _____**I authorize the release of information contained in my patient records, including alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2.**

   _____**I authorize release of information to include psychiatric/psychological services records, and, if any, social work records that include communication by me to a social worker or psychiatrist/psychologist.**

Patient Signature: _____ Date: _____

7. **I understand this authorization is voluntary and is subject to written revocation at any time by notifying the individual(s) or organization releasing this information in writing, except to the extent that Laguna Community Health Center (LCHC) has already taken action in reliance on the authorization. This authorization will expire 90 days after it is signed, upon disclosure of requested information or on (Insert date) _____.**

   I understand the LCHC will not condition treatment or eligibility for care on my providing this authorization, except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information (PHI) for disclosure to a third party.

   I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

Patient Signature: _____ Date: _____

Authorized Representative: _____ Date: _____

Relationship to Patient: _____

** LCHC reserves the right to charge for processing and copying information. This fee is waived when releasing pertinent information directly to a treating physician or health care facility.