7110 Wyoming Blvd NE, Albuquerque, NM 87109
P- 505.346.0500 F- 505.346.0164

Standard Authorization of Use & Disclosure of Protected Health Information

[Release of Information unrelated to Treatment, Payment, & Operations]

Information to be used or Disclosed (Minimum Necessary Rule Applies):

□**Encounter Notes**	□**Laboratory Results**	□**Billing/Insurance Information**
□**Last Examination Only**	□**Imaging Results**	□**Surgical Information**
□**Dictation only**	□**Other**_______________________	

Starting Date of Service: ___________________________Thru Ending Date of Service:___________________________________

A reasonable cost-based charge may apply for duplication, handling, and transmitting/mailing not to exceed $15.00 for the initial 15 pages and .10 per page thereafter per the guidelines of the NM Board of Medical Examiners.

Purpose of Disclosure: The information requested above will be used for the following purposes:

□**Continuing Care**	□**Personal Use**	□**Insurance Claim**
□**Insurance Application**	□**Attorney Use**	□**Other** (list below)

Requesting Party: Self □ SWEC □ Other: ____

Person(s) to whom PHI May Be Disclosed, Authorized to Use & Disclose Information:

Please provide complete contact information (Name, Address, Telephone, Fax, Email, and Account Numbers)

I HEREBY AUTHORIZE:	TO RELEASE TO:
(Name of person or facility which has information)	(Name of person or facility to receive information)
Name/facility: ________________________	Name/facility: ________________________
Address: ________________________	Address: ________________________
________________________	________________________
Phone: ________________________	Phone: ________________________
Fax: ________________________	Fax: ________________________

•Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Southwest Eyecare Specialists. You should contact the Privacy Official to terminate this authorization.

•Potential for Re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Southwest Eyecare Specialists discloses it to another party.

•Rights of the Individual: You may inspect or copy information used or disclosed under this authorization, You may refuse to sign this authorization. If you refuse to sign this authorization, Southwest Eyecare Specialists will not deny you any urgent or emergent treatment, all routine or research-related treatment shall be referred back to your initiating Primary Care Provider.

____

Name of Patient (Print or Type) Date of Birth

____

Signature of Patient

____

Date

____

Signature of Patient Representative Relationship of Patient Representative to Patient

(Required if the patient is a minor or an adult who is unable to sign this form)

Updated: June 2018