

**MEDICAL ASSOCIATES OF  
NORTHERN NEW MEXICO, P.A.  
3917 West Rd. Suite A  
Los Alamos, New Mexico 87544**

**Medical Records Release/Obtain  
Information Authorization  
Phone: (505) 661-8900  
Fax: (505) 661-8916**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Intl. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Phone: \_\_\_\_\_

**I authorize the facility below:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax \_\_\_\_\_

**To release my medical records to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax \_\_\_\_\_

**Information to be released : (Write on line below) FEES MAY APPLY**

All Medical Records  Other: \_\_\_\_\_

**For the purpose of:**

\_\_\_ Continuing Care                      \_\_\_ Insurance                      \_\_\_ Personal Copy  
\_\_\_ Changing PCP                        \_\_\_ Legal Claim                    \_\_\_ (Hand Carry)  
\_\_\_ Disability Determination  
\_\_\_ Other (Specify) \_\_\_\_\_

*I understand my records may contain sensitive information and will be released, unless I indicate below.*

**Do not release:**

\_\_\_ Psychological, psychiatric or other mental impairment(s)(excludes psychotherapy notes).  
\_\_\_ Drug abuse, alcoholism, or other substance abuse.  
\_\_\_ Gene related impairments (including genetic tests results)  
\_\_\_ Communicable/Venereal Diseases (including but not limited to hepatitis, syphilis, gonorrhea, AIDS and tests for HIV)

**Unless otherwise revoked, this authorization expires 2 years from the date of signed release form.**

**I further understand:**

- My signing of this document is voluntary
- I can revoke this authorization at any time and the revocation must be in writing.
- The Federal Privacy laws will not cover the information released.

Patient/Legal Guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Identification of requestor of patient information verified? Yes: \_\_\_ No: \_\_\_ Type: \_\_\_\_\_

*Note: Patients 18 and older must sign their own authorization. The information that relates to privileged information is subject to the following statement: This information has been disclosed to you from our records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of such information without specific written consent of the person to whom the information pertains or is otherwise permitted by state law.*