MEDICAL ASSOCIATES OF NORTHERN NEW MEXICO, P.A.
Phone: 5056618900 Fax: 5056618916 Website: www.mannm.com

3917 West Road, Suite A, Los Alamos, NM 87544

Note: One form per facility/provider only.

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: ____________________ DOB: ____________________ Chart:

Address: ____

City: ____________________ State: ______________ Zip: ______________

Release records from: ____________________	Send records to: ____________________
____________________	____________________
Phone: ____________________	Phone: ____________________
Fax: ____________________	Fax: ____________________

PURPOSE OF RELEASE: (Please circle the appropriate option)

Continuing Care (2 years)	Insurance	Hand Carry	Personal Copy
Changing PCP	Legal Claim	Disability Determination	Authorization to pick up
Other (Specify):			
All Medical Records			
From year: ____________________		To year: ____________________	

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 test results)
_______ Sexually transmitted diseases (STD's) and/or HIV testing or treatment

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

Patient/ Legal Guardian signature: ______________________________ Date: ____________________

Identification of requester 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.

PLEASE FILL OUT THE FORM COMPLETELY. INCOMPLETE FORM IS INVALID.