WOMEN'S MEDICAL
associates

2520 S. Telshor Blvd, Las Cruces, NM 88011 – (575) 522-9793   Fax (575)532-9019

RECORDS RELEASED TO WMA

Authorization of Disclosure of Protected Health Information by Another Covered Entity for Use by Women's Medical Associates

Information to be Used or Disclosed (Information you want released)

Information to be obtained under this authorization includes:

____

If you would like any of the following released, please initial below or those records may not be released.

_____ Psychiatric Notes   _____ Alcohol Use   _____Drug Use   _____ HIV/AIDS Records   _____ STD Records

Purposes of Disclosure (Why you want the information released)

Information listed above will be disclosed for the following purposes:

____

Persons Authorized to Use or Disclose Information (Who you want to release the information)

Information listed above will be used or disclosed by:

Name of Provider: ______________________________________

Name of Facility: ______________________________________

Address: ______________________________________

City, State, Zip: ______________________________________

Phone Number: ______________________________________

Persons to Whom Information May be Disclosed

Information described above may be disclosed to: Women's Medical Associates' Providers and/or Staff

Expiration Date of Authorization

This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Women's Medical Associates. You should be contact the Office Manager to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

Rights of the Individual

[ ] You may inspect or request a copy of information that is used or disclosed under the authorization

[ ] You may refuse to sign this authorization.

____

Name of Patient (Print or Type)   Date of Birth

____

Signature of Patient

____

Date

____

Signature of Patient Representative

____

Relationship of Patient Representative to Patient

Approved: ______________________

Released by: ____________________

Date: __________________________

Mailed: ________________________

Faxed: _________________________

Hold for Patient Pick Up: _________

Updated 6/27/2017 – LG