AUTHORIZATION FOR RELEASE OF MEDICAL & PSYCHIATRIC RECORDS

I, _____ hereinafter referred to as "RELEASOR",

hereby authorize:_____

CITY: _____ **STATE**: _____ **ZIP CODE**: _____

PHONE NUMBER: ( )_____ **FAX NUMBER**: ( )_____

to release any and all medical records for (print name):

PATIENT NAME: _____ **D.O.B.**: _____ /_____ /_____

DATE OF SERVICE: _____

Including but not limited to psychological, psychiatric, alcohol, and drug treatment records and laboratory reports including HIV testing data to:

San Juan Medical Group, P.C. / Farmington Family Practice
Attn: Dr._____
622 West Maple, Suite B
Farmington, NM 87401
Phone: (505) 327-4867 Fax: (505) 327-5355

This authority to release includes, but is not limited to copies of all documents, medical records and reports, x-rays, x-ray reports, diagnostic tests, lab tests, bills for the services you have rendered, and any other information in your possession relative to my past, present or future physical and mental condition.

IN ADDITION, IT IS SPECIFICALLY ACKNOWLEDGED BY RELEASOR THAT SUCH RECORDS MAY INCLUDE AND/OR CONTAIN REFERENCE TO ANY OR ALL OF THE FOLLOWING SUBJECTS AND RELEASOR BY HIS OR HER SIGNATURE APPEARING HEREIN BELOW, NONETHELESS DIRECTS THAT ALL OF THE FOLLOWING MATERIALS ALSO BE RELEASED AS SPECIFIED HEREIN:

(J) Any and all medical records, reports and documents which relate, in any way, to the diagnosis and treatment of drug/alcohol/substance abuse if any.
(K) Any and all medical records, reports and documents which relate, in any way, to the diagnosis and treatment of emotional/mental health/psychiatric condition if any.
(L) Any and all medical records, reports and documents which relate, in any way, to the diagnosis and treatment of Human Immune Deficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS) if any.

The information which related to HIV and AIDS is to be released under Section 24-2B-7 NMSA and this authorization to release this information is subject to the following statements: This information has been disclosed to you from records whose confidentiality is protected by the state law.

This consent is subject to revocation at any time except to the extent that records have previously been provided in reliance on this authorization. If not previously revoked, this release will expire twelve (12) months from the date written below. A photocopy of this authorization shall be considered as effective and valid as the original and shall be honored by those to whom it is provided.

DATE:_____ / _____ / _____ **RELEASOR**: _____