Alameda Acute Care Clinic & Family Medicine

AUTHORIZATION FOR RELEASE/OBTAIN OF INFORMATION

I authorize Alameda Acute Care Clinic & Family Medicine to release / obtain (circle one) medical information concerning:

Patient Name: _____ DOB: _____ Tel: _____

Address: _____ City: _____ State:

_____ Zipcode: _____ Dates of Service: _____

This information is to be released to / obtained from (circle one):
Name/Company:
_____

Address: _____ City: _____ State:

_____ Zipcode: _____

Phone Number: _____ Fax Number: _____

Specific information to be released (circle below):

Nurses' notes & admission assessment
Physician's progress notes/consult reports
Physician's H&P & discharge report
Electrocardiograms & dictated results
Laboratory results
Medical imaging dictated results
Medication administration records
Immunization Records
Other:_____

This information is necessary for the following purposes: (*Indicates possible fee for service)

Follow-up Care
Patient is requesting disclosure**
Disability Benefits*
Attorney*
Other*:_____

Information to be released via: Fax Mail Pick-up Email_____

This authorization is effective immediately and shall remain in effect for one year. I understand that the request may not further use or disclose medical information unless I authorize such further use or disclosure or unless such use is specifically required or permitted by law. I understand that the specific information to be released may include, but is not limited to: history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV/AIDS. I authorize the release of this specific data. I also understand that this authorization may be revoked by me by a written and dated notice, except to the extent disclosure has been made prior to receipt of the revocation.

I have read and understand this consent, and I have signed it voluntarily and of my own free will.

_____
Signature of Patient or Authorized Personal Representative Relationship to Patient

_____
Date

Authorized Personnel Only
Date Received_____ Completed by: _____
Date Processed: _____ Number of Pages: _____

Please fax records to: (505) 387-3937. Thank you.

Alameda Acute Care Clinic & Family Medicine
1111 Alameda Blvd NW
Suite C
Albuquerque, NM 87114
Tel: (505) 346-3704
Fax: (505) 387-3937
www.aaccandfm.com
email: support@aaccandfm.com