HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: American Document Services
Name of Healthcare Provider/Physician/Facility/Medicare Contractor
300 A N. 17th Street
Street Address
Las Cruces, NM. 88005
City, State and Zip Code

RE: Patient Name: _____

Date of Birth: _____ Phone Number: _____

Doctors Office or Physician:_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I agree to pay all fees associated with this release, based on the standard fee outlined below. New Mexico Administration Code Title 16, Chapter 10, Part 17.8 allows for a fee of $30.00 for the first 15 pages and $.25 per page thereafter for each medical record duplicated. I understand that all sections of this form must be completed before it can be processed with **proof of identification**.

_____ _____

Signature of Patient or Legally Authorized Representative Date
(See 45CFR § 164.508(c)(1)(vi))

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Name and Relationship of Legally Authorized Representative to Patient
(See 45CFR §164.508(c)(1)(iv