ROI

AUTHORIZATION FOR USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

ROID0012 (Rev 09/13)

I hereby authorize the use or disclosure of individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

1. Specific description of information that may be used / disclosed (please include date range):
   All health records to include but not limited to admission, history & physical, discharge, consultations, operative reports, laboratory tests, ER record, etc.
   For Time Period To Present

2. I authorize the release of ☐ HIV Tests Results ☐ Behavioral Health Records
   ☒ Drug / Alcohol Treatment Records
   Patient or Legal Representative Signature Required: _____

3. The information will be used/disclosed for the following purpose(s):
   To determine eligibility for financial assistance from the New Mexico Crime Victims Reparation Commission

4. Persons/organizations authorized to use or disclose the information:
   Lovelace Medical Center
   601 Dr. Martin Luther King, Jr. Ave NE
   Albuquerque, New Mexico 87102

5. Persons/organizations authorized to receive the information:
   New Mexico Crime Victims Reparation Commission
   6200 Uptown Blvd NE Ste. 210
   Albuquerque, New Mexico 87110

   Information to be: ☒ Mailed to the above address ☒ Fax to: (505) 841-9437
   ☐ Picked up ☐ Number to call when ready: _____

6. The person/organization authorized to use/disclose the information will receive compensation for doing so. Yes ☐ No ☒

7. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under the NOTES listed at on page 2 of this form.

8. I understand that I may revoke this authorization at any time by notifying Lovelace Health Services in writing at Lovelace Medical Center 601 Dr. Martin Luther King Jr. Ave NE Albuquerque, NM 87102 I except to the extent that:
   a) action has been taken in reliance on this authorization; or
   b) If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

9. This authorization shall expire:_____ [INSERT APPLICABLE DATE OR EVENT]

Request for Electronic Records (Lovelace Medical Center, Westside and Women's only)

☐ I would like to request an electronic copy of my discharge instructions

☐ I would like to request an electronic copy of my patient health information as defined here (including test results, problems, medications, allergies, discharge summary, and procedures). I understand the facility has three business days to provide this copy.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient or representative's authority to act for the patient, if applicable

NOTE: If the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, Lovelace reserves the right to deny treatment associated with such research.

NOTE: If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Lovelace reserves the right to deny that health care.

INTERNAL USE ONLY

Identification Verified: ☐ No ☐ Yes - by: _____

I have received _____ as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

Employee Signature:_____ Printed Name: _____

Date: _____/_____/_____

A copy of this signed form will be provided to the patient.