AUTHORIZATION TO OBTAIN OR RELEASE HEALTH INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name _____ Date of Birth _____

Date range of records from: _____ to: _____

Specific description of information (including date(s), if relevant): _____

What is the purpose of this authorized use or disclosure: □ Attorney □ Doctor/Provider □ Hospital □ Other_____

Expiration Date (1 year expiration)

This authorization will expire on _____ / _____ /_____ (MM/DD/YY) or on the occurrence of the following event:

_____

Person/organization that health information will be **transferred from:**	Person or organization using or **receiving** the information **to:**
□ Eye Associates of New Mexico	□ Eye Associates of New Mexico
□ Other:_____	Name of Provider: _____
_____	Address:_____Fax#: _____

Revocation

This authorization may be revoked at any time by notifying Privacy Officer, Eye Associates of New Mexico, LTD in writing at 8801 Horizon Blvd. NE, Suite 360, Albuquerque, NM 87113. If I revoke this authorization, I understand that it will not have any effect on actions Eye Associates of New Mexico took before it received the revocation.

Section B: Must be completed if health care provider or health plan requested the authorization or authorization is for research.

1. Health care provider or health plan must complete the following:
   a. Will provider or health plan receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____
2. Patient must complete the following:
   a. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. Initials_____
   b. I understand that, in most situations, my healthcare provider will treat me regardless of whether I sign this authorization. If the purpose of the authorization is to allow for research-related treatment, I understand I will not be able to receive that treatment without signing this form. Initials _____
   c. I understand that a health plan may condition enrollment or eligibility for benefits on my signing an authorization releasing requested medical records, other than psychotherapy notes, prior to my enrollment in the plan. However, once I am enrolled, the plan may not refuse to pay for my care, adjust my eligibility for benefits or remove me from the plan if I refuse to sign an authorization. Initials _____

_____ _____

Signature of patient or patient's representative Date

Printed name of patient's representative _____

Relationship to patient _____

Witness _____ Date _____