AUTHORIZATION TO OBTAIN OR RELEASE HEALTH INFORMATION

Complete All Sections, Sign and Date

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/YYYY) 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#: _____

This authorization may be revoked at any time by notifying Privacy Officer, Eye Associates of New Mexico, 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.

I understand that Eye Associates of New Mexico will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

_____ _____
Signature of patient or patient's representative Date

Printed name of patient's representative _____

Relationship to patient _____

Witness_____ Date_____