

Complete all applicable sections, then sign and date. Please print clearly.

**1 PATIENT INFORMATION**

|                                |                                   |
|--------------------------------|-----------------------------------|
| Patient full legal name: _____ | Date of birth (MM/DD/YYYY): _____ |
| Email address: _____           | Previous/other name(s): _____     |
| Current mailing address: _____ | Phone: _____                      |

**2 WHO MAY SEND AND RECEIVE THE RECORDS** Complete both FROM and TO. Required for "Other": Provide the name, mailing address, and at least one contact method (phone or email). Missing information may delay processing.

| FROM — Authorized to disclose                                                                                                                                                                                                                                                                                                                                 | TO — Authorized to receive                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Patient named above <input type="checkbox"/> Personal representative<br><input type="checkbox"/> Eye Associates of New Mexico <input type="checkbox"/> Other provider/person/organization<br>Name: _____<br>Relationship, if applicable: _____<br>Address: _____<br>City/State/ZIP: _____<br>Phone: _____<br>Email: _____ Fax: _____ | <input type="checkbox"/> Patient named above <input type="checkbox"/> Personal representative<br><input type="checkbox"/> Eye Associates of New Mexico <input type="checkbox"/> Other provider/person/organization<br>Name: _____<br>Relationship, if applicable: _____<br>Address: _____<br>City/State/ZIP: _____<br>Phone: _____<br>Email: _____ Fax: _____ |
| Records sent to EANM: CentralizedMedicalRecords@eyenm.com or fax to (505) 933-6698                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                               |

**3 REQUEST DETAILS** Select all that apply.

|                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Purpose: <input type="checkbox"/> Continuing/transfer of care <input type="checkbox"/> Personal use <input type="checkbox"/> Insurance/benefits <input type="checkbox"/> Legal matter <input type="checkbox"/> At the patient's request <input type="checkbox"/> Other: _____         |
| Records: <input type="checkbox"/> Complete record <input type="checkbox"/> Visit notes <input type="checkbox"/> Tests/images <input type="checkbox"/> Operative reports <input type="checkbox"/> Prescriptions <input type="checkbox"/> Billing <input type="checkbox"/> Other: _____ |
| Date range of records (MM/YYYY): From _____ To _____ <input type="checkbox"/> All dates                                                                                                                                                                                               |

**4 EXPIRATION AND REQUIRED NOTICES**

**Expiration.** This authorization expires one year after the date it is signed, unless I revoke it earlier in writing.

**Authorization.** I authorize the person or organization identified under FROM to disclose the selected health information concerning the named patient to the person or organization identified under TO. This authorization is voluntary.

**Redisclosure.** Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy regulations.

**Right to revoke.** I may revoke this authorization at any time by written notice to the Privacy Officer, Eye Associates of New Mexico, 8801 Horizon Blvd. NE, Suite 360, Albuquerque, NM 87113. Revocation will not affect actions already taken in reliance on this authorization.

**No conditioning.** EANM will not condition treatment, payment, health-plan enrollment, or eligibility for benefits on whether I sign this authorization.

**Copy.** I am entitled to a copy of the signed authorization.

**Additional protections.** Information subject to additional legal protections will be disclosed only as permitted by applicable law. This form does not authorize disclosure of psychotherapy notes.

**5 SIGNATURE**

By signing, I confirm that I have read and understand this authorization and that the information provided is complete and accurate.

|                                                                             |                                                                                             |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Signature of patient or personal representative: _____                      | Date signed (MM/DD/YYYY): _____                                                             |
| Printed name of signer: _____                                               | Phone: _____                                                                                |
| If signed by a personal representative, authority to act for patient: _____ | Supporting documentation:<br><input type="checkbox"/> Attached <input type="checkbox"/> N/A |