

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
☐ Eye Associates of New Mexico ☐ Other provider/person/organization Name: _____ Relationship, if applicable: _____ Address: _____ City/State/ZIP: _____ Phone: _____ Email: _____ Fax: _____	☐ Patient named above ☐ Personal representative ☐ Eye Associates of New Mexico ☐ Other provider/person/organization Name: _____ Relationship, if applicable: _____ Address: _____ City/State/ZIP: _____ Phone: _____ Email: _____ Fax: _____
Records sent to EANM: CentralizedMedicalRecords@eyenm.com or fax to (505) 933-6698	

3 REQUEST DETAILS Select all that apply.

Purpose: ☐ Continuing/transfer of care ☐ Personal use ☐ Insurance/benefits ☐ Legal matter ☐ At the patient's request ☐ Other: _____
Records: ☐ Complete record ☐ Visit notes ☐ Tests/images ☐ Operative reports ☐ Prescriptions ☐ Billing ☐ Other: _____
Date range of records (MM/YYYY): From _____ To _____ ☐ 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: ☐ Attached ☐ N/A