SWGA **SOUTHWEST GASTROENTEROLOGY ASSOCIATES, P.C.**

SWE **SOUTHWEST ENDOSCOPY, LTD.**

7788 Jefferson NE • Albuquerque, New Mexico 87109

505-999-1600 **Medical Records Fax 505-999-1655**

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Social Sec. # _____

I hereby authorize _____ located at _____

to disclose information from my health record to:

Name: _____

Address: _____

_____

For the purpose of: _____

Information to be disclosed:

( ) most recent visit
( ) history & physical exam
( ) initial assessment
( ) consultation reports
( ) procedure reports
( ) progress notes
( ) laboratory tests
( ) x-ray reports
( ) pathology reports
( ) entire record
( ) other _____
( ) other _____
( ) other _____

Covering the period(s) of healthcare: From date: _____ To date: _____

From date: _____ To date: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol and drug abuse. It may also include genetic test results and related patient information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Practice Manager of SWGA. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, or event: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date on which it was signed.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure healthcare treatment.

_____ _____

Signature, Patient, or Legal Representative *(Relationship to Patient)* *Date*

_____ _____

Signature of Witness *Date*

Prohibition of redisclosure: Federal Law (42 CFR Part 2) and the state laws (NMSA 1978 section 24-1-9-5 (1996); NMSA 1978 section 32A-6-15 (1995); NMSA 1978 section 24-2A-6 (1997) prohibit further disclosure of HIV/AIDS and other sexually transmitted diseases, and mental health and alcohol abuse and drug abuse information to any person or agency without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or state law.