AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorization for use/or disclosure of Protected Health Information

I hereby authorize ______________________________
Name of Disclosing Party

____
Address

____
City State Zip Code Phone

To disclose to : Las Cruces Surgery Center - Telshor
1205 S. Telshor Blvd, Las Cruces, NM 88011 (575) 522-6144 (575) 521-2600

Check the box and initial to specify which type of information is to be disclosed:

Echocardiogram Report ____________ Date Range ____________
Electrocardiogram Report ____________ Date Range ____________
Lab Results ____________ Date Range ____________
Medical Information____________ Date Range ____________
Operative Report ____________ Date Range ____________
Progress Notes ____________ Date Range ____________
Radiology Report ____________ Date Range ____________
Sleep Study Report ____________ Date Range ____________
Stress Test Results ____________ Date Range ____________
X-Ray Results ____________ Date Range ____________
Other______________________________

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here____________.

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revoation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authoriztion.

Re-Disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specificallhy requried or permitted by law.

____
Patient/Responsible Party Signature Relationship Date

____
Witness Date