# *SCOTT D. ALLEN MD & ASSOCIATES PC*
# *NEW MEXICO EYE CLINIC OF FARMINGTON*
# *2300 E 30TH ST SUITE 105*
# *FARMINGTON NM 87401*
# *(505) 327-0406 FAX (505) 326-4691*
# *Authorization for Disclosure of Protected Health Information*

***I hereby authorize staff of Scott D. Allen MD & Associates/ New Mexico Eye Clinic of Farmington*** **to disclose information from the health records of**:

***Patient Name:*** _____ ***Date of Birth:*** _____

***Address:*** _____

_____

**Release Information To (check one):**

Name/Entity/Facility:_____Attention: _____

Address:_____Phone: _____

City:_____State:_____Zip: _____

Fax: _____

**Delivery Preference (circle one):**

Mail/fax copies to address listed above Hold for patient pick-up

Discuss medical information with: (name)_____, (phone) _____

**Information to Be Released (initial and cirlce):**

All records_____ Mental Health notes_____

Time specific records from_____to_____ Laboratory results_____

Radiology_____ Other healthcare provider records in chart_____

Other (specify records needed): _____

**Purpose for Need or Disclosure (circle one):**

Continued patient care/ Insurance claim/ application

Attorney/legal Change of physician/relocation

Other: _____

*I understand that the information released is for the specific purpose stated above. I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.*

_____ _____

Signature of Patient Relationship to Patient (self, parent, spouse)

Date _____

***Please fax completed form to (505) 326-4691 or mail to address above, attention Medical Records.***