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_____to disclose information from the health records of:
Patient Name: _____ ***Date of Birth:*** _____
Address: _____
_____

Release Information To:

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

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.