NEW MEXICO
Clinical Research &
Osteoporosis Center, Inc.

E. Michael Lewiecki, MD, FACP, FACE - Osteoporosis Director
Lance A. Rudolph, MD - Research Director
Desiree Sanchez, CNP - Adult Healthcare
Cierra Dorado, CNP - Adult Healthcare

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient name	Date of Birth	SS Number (last 4 numbers)
Address (street, city, state, zip code)		Telephone Number

BY: The following individual or organization is authorized to make the disclosure:

NEW MEXICO CLINICAL RESEARCH & OSTEOPOROSIS
(Facility, physician, or organization releasing records)

300 OAK ST NE
(Street)

ALBUQUERQUE, NM 87106
(City, state, and zip code)

TO: This information may be disclosed to and used by the make the disclosure:

(Facility, physician, or organization releasing records)

(Street)

(City, state, and zip code)

The following information is to be disclosed: *(Please check one box for each item)*

Yes	No		Yes	No	
☐	☐	physician/office notes	☐	☐	bone density testing
☐	☐	lab results	☐	☐	consultations
☐	☐	x-ray reports	☐	☐	complete record
☐	☐	hospital dictations			
☐	☐	other_____			

These records are for the purpose of:

☐.....continuing care by another physician
☐.....personal use
☐.....insurance application
☐.....bone density testing
☐.....consultations
☐.....complete record

REQUIRES SPECIAL AUTHORIZATION: Record, reports, information, and information that relate to the diagnosis and/or treatment of the individual will not be released unless consent is specifically given by initialing in the space provided.

- ☐ *Drug or alcohol or substance abuse.*
- ☐ *Emotional or mental health or psychiatric condition.*
- ☐ *Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS).*
- ☐ *Clinical research studies.*

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Unless I have authorized the release of the information referenced in paragraph (c), above, I understand that the results of any HIV tests will not be released. However, the disclosure of my general medical records authorized by this release may contain information pertaining to my HIV status. The information referenced in paragraphs (a), (b), and (c), above, is protected by § 24-2B-7 of the New Mexico Statutes, by federal confidentiality rules (42 CFR Part 2), and by other state and/or federal laws. Information released pursuant to this authorization shall be accompanied by the following statement: "This information has been disclosed to you from records whose confidentiality is protected by state and/or federal law. These laws prohibit further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state and federal law. A general authorization for the release of medical records or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. The law also imposes penalties on the unauthorized disclosure or re-disclosure of this information, including but not limited to providing that a person who makes an unauthorized disclosure of HIV/AIDS test results is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than $500, or both."

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure, and that the information then may not be protected by federal confidentiality rules

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Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other rights:

(a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.
(c) I understand that I have the right to obtain an electronic copy if readily reproducible in that format.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ (Specify date, event or condition of expiration). Federal Law requires an expiration event or an expiration date for an authorization to be valid. Per 45 CFR §164.508(c)(1) (If you do not specify an expiration date, event, or conditions, this authorization will expire in six months)

_____ _____
Patient Signature Date Signed

or

_____
Personal Representative Signature

_____
Description of Personal Representative's Authority

Please Note: Our office may charge a fee for medical record copying. The fee is $30.00 for the first 15 pages and $0.25 for each page thereafter. If you request that your records, be sent to another health care provider for continuing care, as a courtesy, the records will be copied at no charge and sent directly to the specified health care provider.