Sage Neuroscience Center
7850 Jefferson ST NE Suite 300, Albuquerque, NM 87109

505.884.1114 – *Phone* 505.359.3020 – *Fax*

Release of Medical Records

Please Print Clearly and Fill the Form Out Completely.

Incomplete forms are not valid.

I hereby request and authorize the release of medical, mental health, & substance abuse records of:

Patient Name: (*Print Clearly*): _____ **DOB**: _____

Patient Contact Telephone: _____ **SSN**: _____

Check Mark either: ___ ***Releasing Records to;*** ***or*** ___ ***Obtaining from***

Name of Person (*Print Clearly*): _____

Address: _____

_____

Phone: _____ **Fax**: _____

Person named above is: ☐Legal ☐Healthcare Facility/Provider ☐Disability ☐Other (specify): _____

This form allows Sage Neuroscience Center to: Release and/or obtain copies of patient's medical chart

Treatment Period: from (*month/year*) _____ to (*month/year*) _____

Check all that apply:

☐ All Records ☐ Lab Results ☐ Vaccine Records ☐ Any Radiology ☐ Medication Treatment List

☐ Initial Evaluation ☐ Follow Up Visit Notes ☐ Other (specify): _____

All Releases Expire After One Year

By signing this, I am in agreement to the release of information between Sage Neuroscience Center and its providers and the above listed individual/health care providers. I am aware that this release is strictly limited to the contents of my records as checked above. I understand that information regarding active suicidal and homicidal ideation or other known or suspected harm to self or others is not protected under the Health Information Privacy and Portability Act (HIPAA). Disclosing such information is at the discretion of Sage Neuroscience Center to release and would be done so strictly to ensure safety and security. I do not have to sign this authorization in order to receive treatment from Sage Neuroscience Center. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I agree not to hold Sage Neuroscience Center liable for such third-party disclosure. I have the right to revoke this authorization in writing (except to the extent that Sage Neuroscience Center has already acted in response to this authorization), which must be submitted to the Office Manager at the above address. PROHIBITION OF REDISCLOSURE: Federal regulations (42 CFR Part 2) and State Laws (NMSA 1978 43-1-19, 32A-6A-24, 24-2B-7, and 24- 1-9.5) prohibit further disclosure of mental health or alcohol and/or drug abuse treatment information, and the results of tests for HIV/AIDS and other sexually transmitted diseases to any person or agency without securing another proper written authorization for that purpose, or otherwise permitted by Federal regulations or State laws.

_____ _____

Patient Signature ***Date***

If patient is a minor (under 14) or incapable of informed consent, sign below

_____ _____ _____

Parent/Guardian Signature ***Relationship*** ***Date***

Official Use Only:

Date Processed: _____ Tracking #: _____ Initials Done By: _____