SHARED ELECTRONIC HEALTH RECORD

AUTHORIZATION TO RELEASE AND DICLOSE PROTECTED HEALTH INFORMATION (PHI)

Srirengam Muralidhasan, M.D. LLC
1605 El Paseo Rd, Las Cruces NM 88001
P: 575-523-5400 F: 877-539-2504

Note: All applicable fields must be completed for this form to be considered valid.

Please see Las Cruces Urgent Care's website for instructions and contact information and where to send the completed authorization.

PATIENT INFORMATION

Name:______________________ **Date Of Birth:**______________ **Email:** ______________________

Address:____ **Phone:**______________________

City:____________________ **State:**________________ **Zip Code:**______________________

RELEASE INFORMATION TO:

Name/Facility: ______________________________ Phone:______________________

Address:______________________________ Fax:______________________

City:__________________ State:______________ Zip Code:______________________

____ Release medical records ____ Speak to / Discuss

SENSITIVE INFORMATION TO BE RELEASED

I understand that the information to be released may contain sensitive information, and that unless I check the relevant line below, I hereby authorize release of the following types of information:

I DO authorize disclosure of any information related to diagnosis and/or treatment of **Srirengam Muralidhsan, M.D.** ____ **I DO NOT Authorize**
____ **I want to review such mental health information before it is sent**

I DO authorize disclosure of any information relating to Alcohol and/or Drug Abuse. ____ **I DO NOT Authorize**

I DO authorize disclosure of information which refers to **HIV Results, Infection Status and/or Treatment.** ____ **I DO NOT Authorize**

DISCLOSURE FORMAT *If none selected, paper will automatically be sent*

____ Paper ____ Fax

PURPOSE OF RELEASE* *Why is it needed?*

____ ***Patient is Moving***
____ ***Legal Purposes***
____ ***Continuing Care***
____ ***Insurance Purposes***
____ ***Disability Determination***
____ ***Transfer of Care (Last 2 years unless specified)***
____ ***Personal***
____ ***Worker's Comp Claim***
____ ***Other:*** ______________________

INFORMATION TO BE RELEASED *Check appropriate boxes*

Dates of Service: ____ **Last 2 Years** **OR** **From:** ____________ **To:**____________ **All Records** ____

____ Immunizations ____ Radiology Reports

____ Billing ____ Radiology Images (will be released on a CD

____ Labs Only ____ Other: ______________________

Srirengam Muralidhasan, M.D. LLC
1605 El Paseo Rd, Las Cruces NM 88001
P: 575-523-5400 F: 877-539-2504

SENSITIVE INFORMATION TO BE RELEASED

I understand that the information to be released may be from my electronic health record (EHR) and/or paper medical records. I understand that the data from the EHR is current as of the date printed. I understand that in reducing the data to paper, information from the electronic database is being reformatted onto paper and that the page numbers reflect the printed document, not actual pages in the EHR.
I understand that I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences

I understand that I can revoke all or part of this authorization at any time during this time period by providing written notice to the Health Information Management Department, except where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for denial of health benefits of other insurance coverage or benefits

I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information

I understand I am entitled to a copy of this authorization, upon request

This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity during this time period pursuant to this authorization, **unless I notify the HIM Department in writing that no future disclosures should be made.**

Signature:____ Date: ______________________

PrintedName of PersonSigning(ifnotpatient):____

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney):______________________________