Artesia General Hospital

This form, if signed, will authorize Artesia General Hospital to use and disclose certain protected health information about the person named below. This authorization is voluntary, and you may refuse to sign this authorization.

1. I hereby authorize Artesia General Hospital Artesia Healthcare Professionals to disclose protected health information relating to:

   Patient's Full Name: _____

   Patient's Date of Birth: _____

2. The information to be disclosed is: *specify the exact information to be disclosed including dates of service:*

   _____ The entire Medical Record:
   Release of the entire record requires approval from the Privacy Officer according to Minimum Necessary Policy.

   (or the records marked below)

   _____ History and physical examination
   _____ Consultation reports
   _____ X-Ray
   _____ Laboratory Tests
   _____ Discharge Summary
   _____ Progress Notes
   _____ Emergency Room Report
   _____ Cardiopulmonary
   _____ Photographs, videotapes, or digital or other images
   _____ Other: _____

3. I further authorize the following information be released:
   (Please initial if applicable)

   _____ Not applicable
   _____ Acquired immunodeficiency syndrome (AIDS) or human
   _____ immunodeficiency virus (HIV) infection
   _____ Treatment for drug or alcohol abuse
   _____ Mental or behavioral health or psychiatric care

   _____
   Signature ***Date***

4. The persons who are authorized to disclose this information are Artesia General Hospital's Health Information Service Department, or Nursing Staff when the condition necessitates an emergency patient transfer.

5. Artesia Healthcare Professionals will release their own records.

6. The persons who are authorized to receive this information are:

   Name: _____

   Address: _____

   City: _____ State: _____ Zip Code: _____

7. The purposes of the disclosure are: ☐ Continuing / Specialized Treatment;
   ☐ Personal Use; ☐ Payment; ☐ Legal; ☐ Other

   I acknowledge the following statements:

   - *(if applicable)* I understand that Artesia General Hospital may not condition treatment on the completion of this authorization. Patient initials _____

   - I understand that I generally may revoke this authorization at any time by notifying Artesia General Hospital in writing at: Privacy Officer, Artesia General Hospital, 702 N. 13th Street, Artesia, New Mexico 88210, of my intent to revoke this authorization, except that if I do notify Artesia General Hospital in writing of my intent to revoke this Authorization, such revocation will not have any effect on any actions by Artesia General Hospital taken before the revocation.
     Patient initials _____

   - Unless otherwise revoked, this authorization will expire on _____ .
     Patient initials _____

   - I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by _____
     (receiving individual or organization) because it may no longer be protected by federal privacy regulations. Patient initials _____

   - I understand that I may inspect and copy the information to be disclosed pursuant to this authorization form before I sign this form if I ask to do so.
     Patient initials _____

   - I understand that Artesia General Hospital or Artesia Healthcare Professionals will give me a copy of this authorization form after I sign it.
     Patient initials _____

Signature of Patient or Patient's Representative _____

Printed name of Patient's Representative _____

Relationship to Patient _____

Date of Signature _____

Witness _____ Date _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION