

Taos County Emergency Medical Services

105 Albright St. Suite U, Taos, NM 87571

Ph: (575) 737-6430 Fax: (575) 751-7264



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **Taos County Emergency Medical Services** to release healthcare information of the above named patient to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition or dates: _____

All Healthcare information

Other: _____

Definition: I authorize my health information as described above to be released by Taos County Emergency Medical Services to the above named entity for the purpose of continuity of care and understand that:

Yes No

1. Information disclosed pursuant to this Consent/Authorization may include information relating to sexually transmitted disease, AIDS/HIV, and physiological or psychiatric condition, unless restricted as follows.

2. Once information is disclosed pursuant to this signed Consent/Authorization, I understand that the federal privacy law (45 C.F.R parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it.

3. I may revoke this Consent/Authorization at any time, except to the extent that action has been taken in reliance on it. To revoke it, I must request so in writing and sent to Taos County Emergency Medical Services at the address listed above. Revocations will not apply to information that already has been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy, or the policy itself.

4. I may refuse to sign this Consent/Authorization and this refusal will not affect the treatment and evaluation of Taos County Emergency Medical Services provides to the patient, unless the patient is seeking health care services solely for the purpose of creating health information for disclosure to a third party.

Yes No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Attn: Notary- Ensure document is signed in your presence and Name, DOB, and signature info is verified with a Valid ID.

I hereby state that the information attached is true, to the best of my knowledge. I also confirm that the information here is both accurate and complete and relevant information has not been omitted.

Subscribed and sworn to before me by _____

On this _____ day of _____, _____

Signature of Individual

Notary Public

My Commission expires: _____

[NOTARY SEAL]