First Choice
COMMUNITY HEALTHCARE

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient's Full Name: _____Date of Birth: _____ Phone Number: _____

I authorize _____ *(name and complete address of facility)* _____ to release (disclose) the following Health Records of the above mentioned patient to:

- ☐ FCCH South Valley, 2001 N. Centro Familiar, SW Albuquerque, NM 87105; Fax # (505) 877-4400
- ☐ FCCH South Broadway, 1401 William Street, SE Albuquerque, NM 87102; Fax # (505) 924-8204
- ☐ FCCH North Valley, 1231 Candelaria Road, NW Albuquerque, NM 87107; Fax # (505) 344-4056
- ☐ FCCH Alamosa, 6900 Gonzales Road, SW Albuquerque, NM 87121; Fax # (505)831-4123.
- ☐ FCCH Alameda, 7704-A 2nd Street, NW Albuquerque, NM 87107; Fax # (505) 890-1599
- ☐ FCCH Edgewood, 8 Medical Ctr. Rd. /P.O. Box 2606 Edgewood, NM 87015; Fax # (505) 224-8737
- ☐ FCCH Los Lunas, 145 Don Pasqual NW Los Lunas, NM 87031; Fax # (505) 224-8727
- ☐ FCCH Belen, 120 South Ninth Street Belen, NM 87002; Fax # (505) 224-8717
- ☐ Rio Grande School Based Health Center, 2300 Arenal Rd, SW Albuquerque, NM 87105; Fax # (505) 873-0605
- ☐ _____

(Complete Name and Address of facility sending to)

Covering the period(s) of healthcare: from (date) _____to (date) _____.

Information to be disclosed including: ☐ ***ALL records pertaining to my care at First Choice Community Healthcare***

☐ Progress notes	☐ Laboratory tests	☐ Visit summary
☐ X-Ray reports	☐ HEP A, B, C	☐ Dismissal documentation
☐ X-Ray images (Dental)	☐ Outside records from other providers	☐ Billing records

☐ Other information: Please specify: _____

_____ **I understand some documentation related to sensitive conditions below may be incorporated throughout my patient records.**
Initials

In addition to release of the general health records indicated above, by initialing below I also authorize the release of health records pertaining to the following conditions.

_____ Health Records Related to Emotional, Mental Health, Developmental Disabilities, Psychiatric Conditions.
_____ Health Records Related to Drug/Alcohol/Substance Abuse
_____ Health Records Related to Sexually Transmitted Diseases
_____ Health Records Related to Human Immune Deficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)

REVOCATION: This authorization is subject to revocation at any time except to the extent FCCH has already acted in reliance on it. Revocation request must be in writing. Unless revoked, this authorization expires as indicated below:

Indicate expiration date_____: **(Not to exceed one year)**
(Date)

I understand that this authorization to use or disclose health information is voluntary and that I may refuse to sign this authorization. Signing this authorization is not a condition of receiving treatment or payment for services, except as permitted by law. I have read and understand the above information:

Signature of Patient or Parent/Guardian: _____ Date: _____

Relationship if person signing is other than patient: _____ Date: _____