NEW MEXICO ORTHOPAEDICS

505-724-3206 (Phone) 505-724-4401 (Fax)

Authorization to Release Medical Information

WE ARE NO LONGER PROVIDING CD'S. IMAGES WILL BE SENT TO PATIENTS VIA EMAIL

- In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), New Mexico Orthopaedic Associates requires your written consent before disclosing any personal health information.
- This request is valid for **one year** from signature date.
- Your consent to share this information may be revoked in writing at any time, so long as the notification to revoke is signed and dated.
- Any information shared pursuant of this consent may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA privacy rule.

Patient Name: (Print Full Name)_____DOB: _____

I authorize the release of the following health record(s) from New Mexico Orthopaedic Associates:

SPECIFIC INFORMATION INCLUDING:

Medical Records(Dates)_____

Imaging Body Part(s)_____

_____

Other:_____

*Any Office Visits after 1/6/2026 will be in your patient portal. Visits prior to that date will be uploaded to your patient portal.

_____Operative Report(s) Body Part(s)_____

_____MRI Report(s) *these will be in your patient portal behind tests and results

PROTECTED OR SENSITIVE INFORMATION:

Certain information cannot be released without specific authorization**. Please initial below if you agree to release the following:**

_____I recognize that the information disclosed may contain DRUG/ALCOHOL information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____I recognize that the information disclosed may contain MENTAL HEALTH information that is protected by federal and state law. I specifically consent to disclosure of such information.

This information is to be released to me:

Email for images(print):_____

The information below is necessary in order to release your records to a physician outside our facility:

Physician or Clinic Name	
Address, City, State, Zip	
Phone Number	
Fax Number	

Signature:_____Date: _____

Relationship to patient, if other than self: _____

(Rev.) Sept 2026