



Main Office & Clinic
530 DeMoss St.
Lordsburg, NM 88045
575-542-8384
Fax: 575-313-8235

HMS Animas Valley Clinic
#1 Panther Blvd.
Animas, NM 88020
575-548-2742
Fax: 575-313-8235

HMS Cobre Health Clinic
1107 Tom Foy Hwy.
Bayard, NM 88023
575-537-5069
Fax: 575-313-8232

HMS Med Square Clinic
114 W. 11th Street
Silver City, NM 88061
575-388-1511
Fax: 575-313-8236

HMS Mimbres Valley Clinic
2743-B Hwy. 35 North
Mimbres, NM 88049
575-536-3990
Fax: 575-313-8231

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

To be completed by the patient or the patient's representative.

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

I hereby authorize: Hidalgo Medical Services Physician: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

To release my confidential health information, as described below to:

- Me
- Hidalgo Medical Services

Physician: _____ Organization: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

In the following manner:

- Copies by mail
- Copies by fax
- Copies to be picked up
- Inspection
- Other: _____

For the following purposes:

- If requested by the patient, a statement "at request of patient" is sufficient.

My authorization is for the use and disclosure of the following records:

- _____ Statements of Charges and Payments
- _____ Records of Health Center Visits
- _____ Mental Health Records
- _____ Dental Records
- _____ X-Rays and Other Images
- _____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information
- _____ Other: _____
- _____ All of the above

My authorization pertains to information generated on the following date(s) or in the following time period:

My authorization is given freely with the understanding that:

- I may refuse to sign this authorization
- I may revoke this authorization at any time except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- Hidalgo Medical Services may not condition my treatment on my provision of this authorization.
- This authorization is valid for a 365 day period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of this authorization is valid as the original.
- Hidalgo Medical Services, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I will be given a copy of this signed authorization if the authorization is at the request of Hidalgo Medical Services.

This authorization will expire on: _____

Patient's signature

Signature of parent or personal representative

Name of parent or personal representative (please print)

Description of Legal Authority to Act on Behalf of Patient

Acknowledgment of Receipt

To be completed by the patient's personal representative or other person designated in the authorization to receive the requested protected health information when the patient, representative or other person appears at Hidalgo Medical Services in person to receive the information.

I hereby acknowledge that I have received the above requested health information:

Name (please print)

Signature

Date