Corrales Family Practice

3841 Corrales Road
PO Box 2090
Corrales, NM 87048
Ph.: (505) 792-3065 Fax: (505)792-4004

RELEASE OF INFORMATION AUTHORIZATION/REQUEST FORM

Patient Information	Patient Name	
	Address	
	City/State/ Zip	
	Phone #	
	Date of Birth	
RELEASING Facility	Facility Name	
	Address	
	City/State/ Zip	
	Phone #	
	Fax #	
RECEIVING Facility	Name	Corrales Family Practice \ Dr. Alyson Thal
	Address	3841 Corrales Road
	City/State/ Zip	Corrales, NM 87048
	Phone #	(505) 792-9714
	Fax #	(505) 792-4004
Information to be: ☑ Fax to number above		
We do <u>NOT</u> accept disks or thumb-drive etc. If you are unable to fax please mail records to PO box. Date(s) of Service Requested: From _____ To _____		
Behavioral Health Records, HIV, STD	☐ Behavioral Health Records ☐ HIV Records ☐ STD Records ☐ Alcohol/Drug Treatment Records Patient or Legal Representative Signature Required: _____	

- I understand that I may revoke this authorization at any time by notifying the facility releasing the records in writing to the Corrales Family Practice, except to the extent that; action has been taken in reliance on this authorization; or if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
- This authorization shall be in force and effective for one year from the day of signing at which time this authorization to disclose this protected health information expires.

_____ _____
Name of Patient or Patient's Legal Representative Date

_____ _____
Signature of Patent or Patient's Legal Representative Date