GREENVIEW, LLC
AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION

NAME: _____ **DATE OF BIRTH:** _____

Address: _____ **Day Phone:** _____

City: _____ **State** _____ **Zip:** _____

Clinic/Hospital/Health Care Provider –

(***Who*** has the information you want released?) **Please list the specific Hospital and/or clinic.**

NAME: _____

Address: _____ **Day Phone:** _____

City: _____ **State** _____ **Zip:** _____

Receiving Party

(***Where*** do you want the information sent? ***Who*** may have the information?)

Name: Greenview, LLC

Address: 10519 Bitter Creek Drive NW 505-990-3978

City: Albuquerque **State** NM **Zip:** 87114

Fax Number: 505-212-3263

Information to be Released

(***What*** do you want sent or released? Check the appropriate box.)

Indicate date(s) of service Previous 24 months

- ☒ Clinic (office visit, lab, radiology, medicines, immunizations)
- ☒ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology)
- ☐ Billing Records
- ☐ Copies of Films/Images
- ☐ Community Pharmacy Charges
- ☒ Any and all records (includes ALL types of record listed below. If you want to include images and billing records, check those boxes.)

Only records types checked below:

- ☐ Discharge summary/note
- ☐ History & physical exam
- ☐ Operative report
- ☐ Consultations
- ☐ Radiology reports
- ☐ Rehab records (PT/OT/ST)
- ☐ Laboratory reports
- ☐ Progress notes/clinic notes
- ☐ Emergency record(s)
- ☐ Immunization/allergy record
- ☐ Pathology reports
- ☐ Mental health records
- ☐ Medication records
- ☐ Chemical dependency/ Substance abuse records
- ☐ Pathology slides/blocks
- ☐ Other records specify record type(s) _____

Release Instructions

(***How*** and ***When*** do you want the information?)

Date information is needed: ASAP

Release Method / Format requested: (check one)

☐ ***Paper*** ☐ ***CD/DVD*** ☐ ***View my Record*** ☒ ***Fax***

Purpose of Release

(***Why*** is it needed?)

- ☒ **Continuing care**
- ☐ **Other** _____
- ☐ **Transfer of care**
- ☐ **Personal use or review**

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:_____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
- Greenview will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Greenview records may include records that it received from other organizations. If these records have been used by Greenview and filed in the record Greenview maintains about you, Greenview cannot prevent redisclosure of you information by the person or organization who recieves your records under this authorization, and that information may not be covered by state and federal privacy protection after it has been released.
- By signing this authorization, you release Greenview from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____ _____

Patient/Legal Guardian Signature | Date | Relationship to Patient