NEW MEXICO Heart Institute
TRUST US WITH YOUR HEART

502 Elm Street NE
Albuquerque, New Mexico 87102
505-841-1000 **www.nmhi.com**

RELEASE OF PATIENT HEALTH INFORMATION CONSENT FORM

Patient's Name at Time of Treatment: _____

Date of Birth: _____

Release Information to: _____

Address: _____
City State Zip Code

Reason for Release: _____ Phone: _____ Fax: _____

Please initial:

____ I hereby authorize _____ Facility to furnish the above-named individual or company with all medical data and information they may request, as listed below, concerning my illness or injury.

____ I hereby consent to the release of any and all records containing alcohol and/or drug abuse and/or psychiatric diagnosis under the same consideration as outlined above. I understand that such information cannot be released without my specific consent, except in accordance with a court order.

____ I further understand that I have a right to receive a copy of this authorization upon request.

Request for Records from:

Attending Physician: _____ Phone: _____ Fax: _____

Date of Treatment: _____ Emergency/Outpatient Dept.: _____

Information Requested: **[Available in the following format: Paper ☐ CD ☐ Jump Drive ☐]**

❑ ECHOS ❑ Holter Monitors ❑ Cardiac Surgeries ❑ Stress Test/Nuclear ❑ EKG ❑ EP Procedure

❑ Cardiac Caths ❑ Laboratory Test, last 6 months ❑ Device Checks/Pacers ❑ Other: _____

Signed:

_____ _____
Patient, Parent/Legal Guardian Date

Address: _____

Copy Requested of this signed form: ❑ Yes ❑ No

Revocation of Release of Information Form:

____ This consent is subject to revocation by the undersigned at any time except to the extent that we have requested the records, and if not earlier revoked, it shall terminate six (6) months from the date of consent without express revocation.