SOUTHWEST ENDOCRINOLOGY ASSOCIATES, P.A.

Authorized for Release of Medical and Psychiatric Records

_____ hereinafter "PATIENT", in the case of an adult Patient or
(Patient Name)

_____ as Parent, duly appointed Guardian or duly
(Name of Parent/guardian or Personal Representative)
appointed Personal Representative of PATIENT, in the case of a minor deceased PATIENT, hereby unconditionally authorizes SOUTHWEST ENDOCRINOLOGY ASSOC hereinafter the "HEALTH CARE PROVIDER(S)", to release copies or representative specimens of any and all medical and/or psychiatric/psychological records and/or any and all other documentary/tangible materials in HEALTH CARE PROVIDER(S) possession relating to and/or concerning said PATIENT to:

_____
(Name of Person(s), firm(s) or insurer(s) to whom records will be released)

In addition, it is specifically acknowledge by PATIENT, Parent/Guardian or Personal Representative that such medical and/or psychiatric records and/or any other similar documentary/tangible materials may include and/or contain reference to any or all of the following subjects, and PATIENT, Parent/Guardian or Personal Representative nonetheless hereby directs that all of the following materials also be released:

Any and all medical records, reports and/or other documentary materials/tangible materials, which may in any way, relate to and/or concern (Patient, parent/guardian or Personal Representative must initial all categories which apply):

( ) the drug, alcohol, and/or substance abuse history, if any of PATIENT;

( ) the emotional condition, mental health and/or psychological/psychiatric history in any of PATIENT;

( ) any history of Human Immunodeficiency virus (HIV) infection/testing results and/or Acquired Immunodeficiency Syndrome (AIDS), if any in the case of PATINET.

This Authorization shall remain in effect until actual receipt by the HEALTH CARE PROVIDER(S) of a written notice from PATIENT which specifically withdraws and terminates that effect of this Authorization, and a photocopy of this fully-executed Authorization shall be considered as effective and valid as the original and shall be honored by those to whom it is presented. This Authorization shall promptly be made apart of PATIENT'S permanent medical/psychological records and a copy of this Authorization shall accompany the copies of said confidential records, material and/or information released by the HEALTH CARE PROVIDER(S) to the above named person(s), party(ies) and/or entity(ies).

TO THOSE RECEIVING CONFIDENTIAL RECORDS, MATERIAL AND/OR INFORMATION PURSUANT TO THIS AUTHORIZATION:

This information is released subject to the terms of Section 24-2B-7 N.M.S.A. (1978 as amended), and is Authorization to release records, documentary/tangible materials and information is subject to the following statement:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosures of such information without specific written consent the person to whom the information pertains or as otherwise permitted by state law.

_____ _____

Date PATIENT, PARENT/GURADIAN OR PERSONAL REPRESENTATIVE OF PATIENT, AS APPPOPRIATE