AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE PROTECTED HEALTH INFORMATION

Women's Specialists of NM
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Patient Name_____ Date of Birth _____

Address _____ City_____State_____Zip_____

Phone Home # _____ Work # _____ SS # _____

1. I authorize the use or disclosure of the above named individual's health information as described below. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

2. **Request Records From:** (Individual or organization authorized to make the disclosure)

   _____

3. **Release Records To:** (Information listed in #4 below may be disclosed to the following individual or organization)

   Name_____Phone No._____

   Address _____ City_____State_____ Zip_____

4. Specific description of information to be used or disclosed: _____ Entire Record OR

   Specify:_____ from (date) _____ to (date) _____

   Specify:_____ from (date) _____ to (date) _____

5. The information that will be disclosed will be used for the following purposes:

   _____

6. I understand that this authorization may include the release of information relating to:
   - Sexually transmitted diseases (STD) Initials of patient _____
   - Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) Initials of patient _____
   - Developmental disabilities or behavioral and mental health services or conditions Initials of patient _____
   - Treatment for alcohol and drug use Initials of patient _____
   - Records in our possession from an outside provider/ facility Initials of patient _____

7. I hereby expressly waive any laws, regulations or rules of ethics that might prevent any hospital, doctor, psychotherapist, laboratory or other health care provider who has examined or treated the above patient in a professional capacity or otherwise, from releasing such documents. Initials of patient _____

8. I understand I have the right to revoke this authorization at any time by notifying the individual or organization that is authorized to make the disclosure, in writing, 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 the claim or the policy itself. Unless otherwise revoked, this authorization ***will expire on the following date, event or condition***: _____.
   If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

9. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that I have a right to receive a notice of privacy from any health care provider that discloses the above protected health information.

_____ _____

Signature of Patient (or Patient's Representative) Date

_____

Relationship to Patient (if signed by Patient's Representative)