

AUTHORIZATION TO REQUEST HEALTH INFORMATION

Patient Name _____ Date of Birth _____ Medical Record # _____

I hereby authorize the UNM Health Sciences Center to receive information from my health record from:

Requested M.D./or Hospital

Name: _____

Address: _____

For the purpose of treatment for: Neuropsychological Testing

Information to be disclosed:

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> most recent visit/admission | <input type="checkbox"/> progress notes | <input checked="" type="checkbox"/> school records |
| <input checked="" type="checkbox"/> history & physical exam | <input type="checkbox"/> laboratory tests | <input checked="" type="checkbox"/> psychological evaluation |
| <input checked="" type="checkbox"/> initial assessment | <input checked="" type="checkbox"/> x-ray reports | <input checked="" type="checkbox"/> physical therapy evaluation |
| <input checked="" type="checkbox"/> consultation reports | <input type="checkbox"/> pathology reports | <input checked="" type="checkbox"/> speech & language evaluation |
| <input checked="" type="checkbox"/> operative report | <input type="checkbox"/> ER record/outpatient log | <input checked="" type="checkbox"/> occupational therapy |
| <input checked="" type="checkbox"/> discharge summary | | |

Other (please specify) IEPs, psychoeducational testing scores, reports, etc. MRI, CT, EEG, of head/brain, sleep study reports.

Covering the period(s) of healthcare: from (date) _____ Birth _____ to (date) _____ Present _____
from (date) _____ to (date) _____

I authorize that this will include information relating to (initial if applicable):

yes no acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, or other sexually transmitted diseases _____ initial

yes no behavioral health services/psychiatric care _____ initial

yes no treatment for alcohol and/or drug abuse _____ initial

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. 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 from the date on which it was signed.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

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 ensure healthcare treatment.

Please mail the copies of my record to:

- University Hospital, Health Information Mgmt/Medical Record Dept, 2211 Lomas Blvd NE, Albuquerque, NM 87106
- UNM Psychiatric Center, Health Information Mgmt/Medical Record Dept , 2600 Marble NE, Albuquerque, NM 87131
- UNM Children's Psychiatric Center, Health Information Mgmt, 1001 Yale Blvd NE, Albuquerque, NM 87131
- Carrie Tingley Hospital, Health Information Mgmt Dept, 1127 University Blvd NE, Albuquerque, NM 87102
- UNM Cancer Research & Treatment Center, Health Information Mgmt Dept, MSC 08 4630, 1 University of New Mexico, Albuquerque, NM 87131

UNMHSC Clinic/Department: Neuropsychology•Department of Psychiatry•

MSC 09 5030•1 University of New Mexico•2400 Tucker NE•Albuquerque, NM 87131-0001

Signature, Patient, or legal representative (Relationship to patient) (Date)

Signature of Witness (Date) (Parent, if CPH/PFC&A patient over 14) (Date)