AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name:_____ **Date of Birth:**_____ **Medical Record #:**_____

1. I hereby authorize the UNM Health Sciences Center to disclose information from my health record at:

[ ] University Hospital
[ ] Children's Psychiatric Hospital
[ ] UNM Medical Group, Inc.
[ ] UNM Psychiatric Center
[ ] UNM Cancer Center
[ ] UNM Sandoval Regional Medical Center
[ ] Carrie Tingley Hospital
[ ] Ambulatory Care Center
[ ] Other--please specify_____

To: Name: _____
Street Address:_____ **City**_____
State: _____ **Zip:**_____ **Phone:**_____**Provider/Facility Fax :**_____

Would you like a CD/DVD of your records? Yes / No **Would you like a CD/DVD of your radiology films/images? Yes / No**

For the purpose of: _____

2. Information to be disclosed:

[ ] most recent visit/admission
[ ] history & physical exam
[ ] discharge summary
[ ] physical / occupational therapy records
[ ] operative reports
[ ] outpatient clinic records
[ ] laboratory tests
[ ] radiology reports
[ ] pathology reports
[ ] ER records
[ ] reproductive health records
[ ] immunization records
[ ] psychological records
[ ] consultation reports
[ ] speech & language records
[ ] all records

Covering the period(s) of healthcare: From (date):_____ To (date):_____
From (date):_____ To (date):_____

3. <u>Your initials are required to release the following information; please initial each line below:</u>

_____ Reproductive health services/care
_____ Laboratory tests
_____ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection or other sexually transmitted diseases.
_____ Behavioral health services/psychiatric care.
_____ Treatment for alcohol and/or drug abuse.
_____ Genetic test results and related patient information.

4. 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.

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

6. I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this authorization and need not sign this authorization to obtain health care treatment; and that if I authorize the disclosure of this health information, I have the right to examine and copy the information to be disclosed. A copy of this signed authorization will be provided to me.

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

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

PROHIBITION OF REDISCLOSURE: Federal regulations (42 CFR Part2) and State Laws (NMSA 1978 ## 43-1-19, 32A-6A-24-2B-7 and 24-1-9.5) prohibit further disclosure of mental health or alcohol and/or drug abuse treatment information and of the results of tests for HIV/AIDS and other sexually transmitted diseases to any person or agency without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or State laws.

If this authorization is not complete, signed and dated, it will be returned and result in the information not being released until complete.