

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

1. Inhereby authorize the UNM Health Sciences Center to disclose information from my health record at: University Hospital UNM Sephiatric Center Carrie Tingley Hospital UNM Cancer Certifer Carrie Tingley Hospital UNM Cancer Certifer Carrie Tingley Hospital UNM Cancer Certifer Content Carrie Tingley Hospital UNM Cancer Certifer UNM Sandoval Regional Medical Center Content Carrie Tingley Hospital UNM Cancer Certifer UNM Sandoval Regional Medical Center Content Carrie Tingley Hospital UNM Cancer Certifer UNM Sandoval Regional Medical Center Catrie Tingley Hospital UNM Cancer Certifer UNM Sandoval Regional Medical Center Catrie Tingley Hospital UNM Cancer Certifer UNM	Patient Name:		Date of Birth:	Medical Re	Medical Record #:	
Children's Psychiatric Hospital JUNM Cancer Center JUNM Sandoval Regional Medical Center JUNM Sandoval Me						
Street Address: 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 For the purpose of: 2. Information to be disclosed: [] outpatient clinic records [] immunization records [] history & physical exam [] laboratory tests [] psychological records [] discharge summany [] radiology reports [] consultation reports [] physical /occupational therapy records [] pathology reports [] speech & language records [] operative reports [] Fer ecords [] all records [] all records [] all records [] reproductive health records [] all records [] all records [] all records [] all records [] reproductive health records [] all r	[] Childr	en's Psychiatric Hospital Medical Group, Inc.	[] UNM Cancer Center [] UNM Sandoval Regiona	[] Ambulatory Medical Center		
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Would you like a CD/DVD of your records? Yes / No Would you like a CD/DVD of your radiology films/images? Yes For the purpose of: 2. Information to be disclosed: [] most recent visit/admission [] outpatient clinic records [] immunization records [] history & physical exam [] laboratory tests [] psychological records [] discharge summary [] radiology reports [] consultation reports [] physical / occupational therapy records [] pathology reports [] speech & language records [] operative reports [] Er records [] all records [] reproductive health records Covering the period(s) of healthcare: From (date):		Street Address:		City	City	
For the purpose of: 2 Information to be disclosed: [] most recent visit/admission		State: Zip:	Phone:	Provider/Facilit	y Fax :	
2. Information to be disclosed: most recent visit/admission	Would y	ou like a CD/DVD of your rec	ords? Yes / No Would you	ı like a CD/DVD of your radiolo	gy films/images? Yes / No	
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[] operative reports [] reproductive health records [] reproductive health records Covering the period(s) of healthcare: From (date):	[] discha	arge summary				
Covering the period(s) of healthcare: From (date):	[]physica	al / occupational therapy records			e records	
Covering the period(s) of healthcare: From (date):	[] opera	tive reports				
3. Your initials are required to release the following information; please initial each line below: Reproductive health services/care Laboratory tests Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection or other sexual 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 writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not information that has already been released in response to this authorization. I understand that the revocation will not on information 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 signes. 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 not sign this authorization to obtain health care treatment; and that if I authorize the disclosure of this health information, I have the rigexamine 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)						
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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 disclosu	Signatui	re of Witness (Da	ate) (Parent, if CPH/F	PFC&A patient over 14)	(Date)	
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If this authorization is not complete, signed and dated, it will be returned and result in the information not being released until complete.

without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or State laws.