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
[ ] 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. I further authorize that this disclosure of health information will include information relating to (initial if applicable):

(Please initial and check "yes" if labs and/or behavioral health records are requested.)

[ ] Yes [ ] No Laboratory tests. _____ *initials.*
[ ] Yes [ ] No Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection or other sexually transmitted diseases. _____ *initials.*
[ ] Yes [ ] No Behavioral health services/psychiatric care. _____ *initials.*
[ ] Yes [ ] No Treatment for alcohol and/or drug abuse. _____ *initials.*
[ ] Yes [ ] No Genetic test results and related patient information. _____ *initials.*

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.