HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

New Mexico Human Services Department
AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Name			Request Date
Mailing Address			Telephone Number
City	State	Zip Code	Medicaid or Social Security #

I AUTHORIZE:

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

☐ **To Release Information TO** ☐ **To Obtain Information FROM**

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

The purpose of the authorization is: (Select the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Medical Providers
☐ Participation in Research Study ☐ Marketing ☐ Creating Health Information for Disclosure to a Third Party
☐ Other: (Specify) _____

I authorize the release of the following health information: (Place an "X" in the box(es) that apply to the information you want released or you want to obtain. Authorization for release of psychotherapy notes may not be combined with authorization for release of other medical records – use separate forms if needed.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Treatment Plan ☐ Prescriptions
☐ Immunizations ☐ Hospital Discharge Summary ☐ Laboratory Results ☐ Imaging Reports
☐ Psychotherapy Notes
☐ Records from (date) _____ to (date) _____
☐ Records related to the following specific condition(s), test(s) or treatments(s): _____
_____
☐ Other: _____

This authorization shall expire (date or event):_____. I understand that if I do not specify an expiration date, this authorization will expire six months from the date on which it was signed.

I understand that I may revoke this authorization at any time in writing.

I have read and understand the *Important Information about Authorization* contained on the back of this page.

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

If signed by Personal Representative, basis of authority: _____

For HSD Use When Requesting Records:

I am authorized to receive this disclosure. Documentation of the above Personal Representative has been obtained.

_____ _____
Signature and Title of Agency Representative Date

IMPORTANT INFORMATION ABOUT AUTHORIZATION

The New Mexico Human Services Department's (HSD'S) policies and your rights are more fully described in HSD's Notice of Privacy Practices, available by writing to the address at the bottom of this page.

- An authorization to release or obtain health information is voluntary. You do not have to sign this form. You will not be required to sign an authorization in advance as a condition of receiving treatment (except research-related treatment) or payment for health care services, except in a few instances where your eligibility for Medicaid depends on HSD verifying your health information.

- In order for HSD to fully provide some of our services, we may need your authorization to use, disclose or obtain your health information.

- If you agree to sign this authorization to release or obtain information, you will receive a signed copy of the form.

- If your authorization is required by law or policy, HSD may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization. HSD will use and disclose your health information in the manner you have authorized on the signed authorization form.

- You may be required to sign an authorization before receiving research-related treatment.

- A separate signed authorization form is required for the use and disclosure of psychotherapy notes.

- Although you have a right to revoke an authorization in writing at any time, HSD cannot take back any uses or disclosures already made before an authorization was cancelled.

- Information used or disclosed by this authorization might be re-disclosed by the recipient and will no longer e protected by HSD privacy policies.

It is your right to file a privacy complaint and to revoke an authorization

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how HSD has used or disclosed information about you. Your benefits will not be affected by any complaints you make. If you file a complaint, cooperate in any investigation or refuse to agree to something that you believe to be unlawful, it will not be held against you.

You may also write to the address below to revoke an authorization you gave to HSD:

New Mexico Human Services Department
HIPAA Privacy Officer
PO Box 2348
Santa Fe, NM 87504-2348
Phone: 1-888-997-2583