NEW MEXICO DEPARTMENT OF HEALTH
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This authorization allows the Department of Health (DOH) to disclose confidential health information about you. The authorization may be revoked. It will remain in effect for six (6) months unless a different time is stated. You are entitled to a copy of the completed authorization. There may be fees charged for any copying associated with this request. If you are a person with a disability and you require this authorization in an alternative format or require a special accommodation to complete this form, you may request assistance from staff at any DOH location or from the DOH Chief Privacy Officer.

(Please print)

CLIENT

Client Name (First, Middle, Last)	Date of Birth (mm/dd/yyyy) / /
Client Address (Street or P.O. Box, City, State, Zip Code)	

1. I authorize the use or disclosure of the health information as described below.
2. I understand that any information disclosed may include information relating to Sexually Transmitted Diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse and information obtained by the New Mexico Department of Health from other providers.
3. I understand that my alcohol and/or drug treatment records are protected under Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by regulation.
4. This authorization applies to health information to be disclosed by:
   - __ (a) The following DOH location: _____
   - __ (b) Any DOH location where the health information may exist.
5. The type and amount of information to be disclosed is as follows (include dates where appropriate):

a.	_ Treatment Plan	from (date) __/__/__	to (date) __/__/__	or	_ Most Recent Only
b.	_ Immunization Record	from (date) __/__/__	to (date) __/__/__	or	_ Most Recent Only
c.	_ History	from (date) __/__/__	to (date) __/__/__	or	_ Most Recent Only
d.	_ Physical	from (date) __/__/__	to (date) __/__/__		
e.	_ Discharge Summary	from (date) __/__/__	to (date) __/__/__	or	_ Most Recent Only
f.	_ Laboratory Results	from (date) __/__/__	to (date) __/__/__	or	_ Most Recent Only
g.	_ X-ray and Imaging Reports	from (date) __/__/__	to (date) __/__/__	or	_ Most Recent Only

h. _ Consultation Reports: from (doctors' names) _____
i. Other: _____
j. Special instructions or limitations: _____

5. This health information shall be disclosed to and used by the following individual or organization: (Please print)

RELEASE TO

Name of Individual or Organization
Individual or Organization Address (No. and Street, City, State, Zip Code)
For the purpose of:

(If the client initiates the authorization and does not elect to provide a statement of purpose, then the statement, "at the request of the individual" is adequate.)

6. This authorization will expire in six (6) months unless another expiration date is specified here: __/__/__ .
(mm/dd/yyyy)

STATEMENT OF UNDERSTANDING:

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 to the DOH Chief Privacy Officer. 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. I understand that unless I revoke this authorization as stated above, this authorization will expire in six (6) months unless I have specified a different date of expiration. 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 receive treatment from DOH. I understand that I may inspect or receive copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the redisclosure may not be protected by federal confidentiality rules. I have a right to limit the information disclosed.

To revoke this authorization or if you have a question about disclosure of your health information, contact the Chief Privacy Officer.
Chief Privacy Officer - NM Department of Health - Office of General Counsel - P.O. Box 26110 - Santa Fe, New Mexico - 87502-6110

SIGNATURES

Signature of Client or Personal Representative	Date (mm/dd/yyyy) / /
If Signed by Personal Representative, Relationship to Client	
Signature of Witness	Date (mm/dd/yyyy) / /

L USE ONLY

Source System: _____ (The system name into which the client is entered)

Client ID: _____ (The client identifier from the Source System)