Authorization for Release of Protected Health Information

Date:________________________ Name of Patient/Client:_____________________________

Social Security #:_____________________ Medical Record #: __________________________

Date of Birth: _____________________

I hereby authorize (Name of Disclosing Party): _____________________________________

____
(Address, City, State, Zip of Disclosing Party)

To disclose to (Name of Recipient): ____

____
(Address, City, State, Zip of Recipient)

The following Information (*Check box to indicate the type of information to be used or disclosed):*

☐ Complete medical record ☐ Complete billing record/itemized bill ☐ Dental records

☐ Psychotherapy notes ☐ Mental health records ☐ X-Ray or other diagnostic images

☐ Lab test results ☐ Immunization records ☐ Other (specify):______________________

To the extent my records contain information about drug and/or alcohol abuse or treatment, I agree to the release of this information: ☐ Yes ☐ No

To the extent my records contain information about sexually transmitted diseases, Hepatitis B & C testing and/or treatment, or HIV/AIDS testing and/or treatment, I agree to the release of this information: ☐ Yes ☐ No

Identify dates of service of records to be used/disclosed:

☐ All dates of service ☐ Specific dates - from:_____________ to: ________________

Describe purpose of use/disclosure of PHI: ____

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☐ At request of individual (*check here if patient/client is requesting the release and does not wish to provide the purpose)*

Revocation. I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to the PMS Privacy Officer at Presbyterian Medical Services, P.O. Box 2267, Santa Fe, NM 87504-2267, and that the revocation will be effective except to the extent that action has already been taken in reliance on this Authorization. Unless revoked, this Authorization will expire one year from the date of signature or on the following date or event:

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Re-disclosure. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy requirements unless otherwise prohibited by law. PMS, its affiliates, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

No denial of treatment/payment. I understand that I do not have to sign this Authorization and that my treatment or payment for services will not be denied if I do not sign this Authorization unless such treatment is solely for purposes of providing health information to a third party (e.g., my employer). I also understand that I may review and copy the information to be disclosed, and that I have a right to receive a copy of this Authorization form.

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Signature of Patient/Client, Parent or Legal Guardian Date

____

Print Name of Patient/Client, Parent or Legal Guardian

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If Signed by Legal Guardian, Description of Legal Authority to Act on Behalf of Patient/Client

COPY OF COMPLETED & SIGNED HIPAA AUTHORIZATION FORM GIVEN TO PATIENT/CLIENT? ☐ **Yes** ☐ **No**

Authorization Form Processed By: ____

Name/Title of PMS Employee **Date**

DISCLOSURE OF HIGHLY SENSITIVE INFORMATION

The information in this document contains confidential information and intended solely for the recipient. If you are not the intended recipient, please contact sender immediately or if unable to reach sender call PMS Central Office at (800) 477-7633. To the extent the information disclosed concerns, sexually transmitted diseases, HIV/ AIDS, or drug and/or alcohol abuse or treatment, such information has been disclosed to you from records protected by State and Federal confidentiality rules (including, without limitation, 42 CFR Part 2 and NMSA 24-1-9.4; 24-2B-7). These State and Federal rules prohibit you from making further disclosure of this information unless expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2, and applicable New Mexico regulations. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Under New Mexico law, a person who makes an unauthorized disclosure of sexually transmitted disease information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500), or both.