Authorization to Release Information

Please Revoke
Date: _____
Reason: _____
_____
_____
Staff: _____
Client: _____

I hereby authorize:

Albuquerque Health Care for the Homeless PO Box 25445
Albuquerque, NM 87125-0045

To use and disclose a copy of the specific information described below regarding:

Client's Name: _____
Last First Middle Maiden or Other Name

_____ _____ _____
Date of Birth Social Security # Telephone #

Address: _____
City State Zip Code

To: _____
Name of Recipient

Address: _____
City State Zip Code

_____ _____
Telephone # Fax #

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

- ☐ Medical Progress Notes Dates: _____
- ☐ History and Physical Exam Dates: _____
- ☐ Medical Diagnosis Dates: _____
- ☐ Lab Reports Dates: _____
- ☐ Verbal Communication Dates: _____
- ☐ Other _____ Dates: _____
- ☐ Dental Notes Dates: _____
- ☐ Dental X-Ray Reports Dates: _____
- ☐ Case Management Dates: _____
- ☐ Verification of Participation Dates: _____

PURPOSE OF DISCLOSURE:

- ☐ Changing Physicians
- ☐ Continuing Care
- ☐ School
- ☐ Workers Compensation
- ☐ Other: _____
- ☐ Consultation/Second Opinion
- ☐ Legal
- ☐ Insurance
- ☐ Housing
- ☐ Disability Determination

I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION RELATING TO:

- ☐ Substance Abuse (including alcohol/drug abuse)** Dates: _____
- ☐ Behavioral Health Notes* Dates: _____
- ☐ Behavioral Health Assessment Dates: _____
- ☐ Behavior Health Treatment/Service Plan Dates: _____
- ☐ HIV related information (AIDS related testing) Dates: _____
- ☐ Genetic Testing Dates: _____

*AHCH does not maintain psychotherapy notes that are separated from the rest of the medical record, but recognizes that HIPAA requires a separate, specific authorization for release of such documents and therefore expressly excludes such notes in this form as an acknowledgment of the prohibition.

**Records from a substance use disorder program governed by 42 CFR, Part 2 confidentiality requirements are not included and require a separate authorization.

_____
Signature of Client or Legal Guardian Date

Authorization to Release Information

1. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.

2. I understand I may see and may have a copy of the information described on this form if I ask for it, and that I ca n get a copy of this form after I sign it.

3. I have been informed that Albuquerque Health Care for the Homeless will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

4. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

5. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

6. I understand that in compliance with New Mexico statute, I may be asked to pay a fee of $5.00 after the first request. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

7. I hereby expressly waive any rules of ethics that might prevent any hospital, doctor, psychotherapist, laboratory or other health care provider who has examined or treated the above patient in a professional capacity or otherwise, from releasing such documents.

8. A copy of this authorization is as effective as the original.

9. I understand that this authorization will expire one (1) year after I have signed this form or on ___ \ ___

_____ Or _____

Signature of Client Date | Parent/Legal Guardian/Authorized Person Date

Relationship to Patient

Records Provided To: _____

Via:

- ☐ Mail Date: _____
- ☐ Hand Delivered to: _____ Date: _____
- ☐ Other (specify): _____ Date: _____

For Office Use Only	
Medical Record #	Date Request Filled
Staff Member Who Processed the Request	Fee collected: $
Identification Presented	