# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Release of Information

*Please read this entire form before signing and complete all the sections that apply to your decisions related to the disclosure of protected health information*

**Patient/Member Name:** _____ **Date of Birth:** _____
PRINT NAME MM/DD/YYYY

**Address:** _____ **Phone Number:** (____)_____

**Medical Record Number** (optional): _____

**Presbyterian Health Plan Member Number** (optional): _____

I authorize Presbyterian Healthcare Services to use or disclose my protected health information to:

**Name:** _____

**Address:** _____ **Phone Number:** (____)_____

**FAX Number:** (____)_____

**Information from (date)** _____ **to (date)** _____ **can be released.**
MM/DD/YYYY MM/DD/YYYY

**Type of information allowed to be released (more than one can be selected):**

___ Abstract (e.g. History & Physical, Consults, Procedure/Operative Notes, Discharge Summary, Lab/X-ray reports)
___ Office notes ___ Lab reports ___ X-ray reports
___ Benefits ___ Billing or claims information ___ Prior Authorizations
___ Notes and Test Results related to: _____
___ Other _____

**Reason for Disclosure:**

___ Treatment/Continuing Medical Care ___ Legal Purposes ___ Personal Use
___ Disability Determination ___ School ___ Employment
___ Billing or Claims ___ Insurance
___ Other _____ ___ Care Management/Care Coordination

**Authorization to Discuss Health Information:**

By initiating here ___ I authorize _____ to discuss my health
(Name of individual health care provider)
information with my attorney, a governmental agency, or other _____
(Attorney/Firm, Governmental Agency, or Other Individual)

**Your initials are required to release the following information:**

___ Sexually transmitted infections/diseases (STI/STD)
___ HIV/AIDS Test Results/Treatment *(This information has been disclosed to you from records whose confidentiality is protected by State law. State law prohibits you from making any further disclosure of such information without the specific consent of the person to whom such information pertains, or as otherwise permitted by State law. NMSA 1978, §24-2B-7)*
___ Behavioral/Mental Health Information
___ Drug, Alcohol, or Substance Abuse Records
___ Genetic Information

*PROHIBITION OF RE-DISCLOSURE: Federal regulations (42 CFR Part 2) and State Laws (NMSA 1978, §24-1-9.6; §24-2B-7; §32A-6A-24; and §43-1-19) 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 infections/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.*

PATIENT IDENTIFICATION

**Reverse side MUST be completed**

PRESBYTERIAN

I understand that this Authorization will expire within six (6) months or
**On a Specific Date:** _____ **Other:** _____
MM/DD/YYYY

◊ I understand this Authorization is voluntary. I understand that I may refuse to sign this Authorization, and that my refusal to sign this Authorization will not affect my/the patient or member's ability to obtain treatment, payment, enrollment, or eligibility for benefits.

◊ I under that this Authorization can be revoked/cancelled in writing at any time, except to the extent that action has been taken in reliance of this Authorization. The revocation/cancellation must be signed by me or on my behalf and sent to the address below.

◊ I understand that the information released may be subject to re-disclosure by some recipients and may no longer be protected by federal and state privacy rules related to health information. I understand that I have a right to a copy of this signed Authorization.

**SIGNATURE:** _____ **Date:** _____
**Signature of Individual or Individual's Legally Authorized Representative** **MM/DD/YYYY**

**Printed Name of Legally Authorized Representative (if applicable):** _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian Other: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted infections, drug, alcohol or substance abuse, and mental health treatment.

**SIGNATURE:** _____ **Date:** _____
**Signature of Minor Individual** **MM/DD/YYYY**

**Submit request to one of the following:**

(1) Health Information Management/Medical Records Department
PO BOX 26666, Albuquerque, NM 87125-6666
(2) FAX: 1-505-841-1153
(3) Email: phsroi@phs.org
*Questions:* 1-505-841-1944

***Additional Information:***

- *Notice: If you send health information to Presbyterian Healthcare Services via email, please know that your message may be sent in an unencrypted email. An unencrypted email means there is a risk that the information in the email and any attachments could potentially be read by a third party when it is sent through the Internet.*
- *If other than the patient's signature, a copy of legal paperwork verifying the patient or member's personal representative **MUST** accompany the request (e.g., court appointed guardian, durable power of attorney for health care).*
- *For a deceased patient/member, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court or trustee must accompany an authorization signed by the named individual.*

**If this Authorization is not complete, signed and dated, it may be returned and result in the information not being released until complete.**