THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____ **Medical Record #:** _____

1. I hereby authorize the UNM Health Sciences Center to disclose information from my health record at:

[X] University Hospital
[ ] UNM Psychiatric Center
[ ] Carrie Tingley Hospital
[ ] Children's Psychiatric Hospital
[ ] UNM Cancer Center
[ ] Ambulatory Care Center
[ ] UNM Medical Group, Inc.
[ ] UNM Sandoval Regional Medical Center
[ ] Other (please specify) _____

Would you like the information on CD/DVD?: Yes/ No

To: Name: New Mexico Crime Victims Reparation Commission
Address: 6200 Uptown Blvd NE Ste 210 Albuquerque, NM 87110
Phone: (505) 841-9432

For the purpose of: Determining eligibility for financial assistance

2. Information to be disclosed:

[X] most recent visit/admission
[X] history & physical exam
[X] initial assessment
[X] consultation reports
[X] operative report
[X] discharge summary
[X] Other (please specify) _____
[X] progress notes
[X] laboratory tests
[X] x-ray reports
[X] pathology reports
[X] ER record/outpatient log
[X] Billing
[ ] school records
[X] psychological evaluation
[X] physical therapy evaluation
[X] speech & language evaluation
[X] occupational therapy

Covering the period(s) of healthcare: from (date) _____ to (date) _____
from (date) _____ to (date) PRESENT

3. I further authorize that this disclosure of health information will include information relating to (initial if applicable):

[X] yes [ ] no acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, or other sexually transmitted diseases _____ initial ✓
[X] yes [ ] no behavioral health services/psychiatric care _____ initial ✓
[X] yes [ ] no treatment for alcohol and/or drug abuse _____ initial ✓
[X] yes [ ] no genetic test results and related patient information _____ initial ✓

4. 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 and present my written revocation to the Health Information Management Department. 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date on which it was signed.

5. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

6. I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this Authorization and need not sign this Authorization to obtain health care treatment; and that if I authorize the disclosure of this health information, I have the right to examine and copy the information to be disclosed. A copy of this signed Authorization will be provided to me.

✓ Self ✓

Signature, Patient, or legal representative (Relationship to patient) (Date)

_____

Signature of Witness (Date) (Parent, if CPH/PFC&A patient over 14) (Date)

PROHIBITION OF REDISCLOSURE: Federal regulations (42 CFR Part 2) and State laws (NMSA 1978 §§ 43-1-19, 32A-6A-24, 24-2B-7 and 24-1-9.5) 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 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.