

**AUTHORIZATION FOR USE OR DISCLOSURE
OF HEALTH 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 initialing 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



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 understand 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.