NEW MEXICO AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Name			Request Date
Mailing Address			Telephone Number
City	State	Zip Code	Medicaid or Social Security #

I AUTHORIZE:

Name: ______________________________

Mailing Address: ______________________________

City, State, Zip Code: ______________________________

Relationship: ____________________ Telephone Number: ______________

☐ **To Release Information TO** ☐ **To Obtain Information FROM**

Name: ______________________________

Mailing Address: ______________________________

City, State, Zip Code: ______________________________

Relationship: ____________________ Telephone Number: ______________

The purpose of the authorization is: (Select the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Medical Providers
☐ Participation in Research Study ☐ Marketing ☐ Creating Health Information for Disclosure to a Third Party
☐ Other: (Specify) ______________________________

I authorize the release of the following health information: (Place an "X" in the box(es) that apply to the information you want released or you want to obtain. Authorization for release of psychotherapy notes may not be combined with authorization for release of other medical records – use separate forms if needed.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Treatment Plan ☐ Prescriptions
☐ Immunizations ☐ Hospital Discharge Summary ☐ Laboratory Results ☐ Imaging Reports
☐ Psychotherapy Notes
☐ Records from (date) ______________ to (date) ______________
☐ Records related to the following specific condition(s), test(s) or treatments(s): ______________

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☐ Other: ______________________________

This authorization shall expire (date or event):______________. I understand that if I do not specify an expiration date, this authorization will expire six months from the date on which it was signed.

I understand that I may revoke this authorization at any time in writing.

I have read and understand the *Important Information about Authorization* contained on the back of this page.

______________________________ ______________

Signature of Individual or Personal Representative Authorized by Law Date

If signed by Personal Representative, basis of authority: ______________________________

For Use When Requesting Records:

I am authorized to receive this disclosure. Documentation of the above Personal Representative has been obtained.

______________________________ ______________

Signature and Title of Agency Representative Date