Behavioral Health, Community Wellness, Health Services, Public Health Programs, Senior Citizens, Social Services, and Vocational Rehabilitation Programs

Authorization for Release of Information

I. I, ________________________________, hereby request the disclosure of information from my record.
(Name of Consumer)

II. **The information is to be disclosed by:** **And is to be provided to:**

The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY	NAME OF FACILITY
ADDRESS	ADDRESS
CITY/STATE/ZIP CODE	CITY/STATE/ZIP CODE

III. **The purpose or need for this disclosure is:**

____

IV. **The information to be disclosed from my health record:** (*check appropriate box(es)*)

☐ Entire Record
☐ Only Information related to *(specify)* ____
____
☐ Only the period of events from ____________________ to ________________________
☐ Other *(specify)* ____
☐ **Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)**

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)

V. I understand that I may revoke this authorization in writing submitted at any time to the Jemez Health & Human Services, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date *or expiration event.*

____
(Enter if date is different from **one year after** date below)

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

Signature of Consumer/Authorized Representative: ______________________________Date: ____________

DOB: ________________________ SSN: ___________________________

Jemez Health & Human Services
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