WOMEN'S HEALTH SERVICES
PATIENT AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION TO THIRD PARTIES

PATIENT NAME: _____ _____/_____/_____
Last First MI Date of Birth

The undersigned hereby authorizes disclosure of protected health information

FROM:

_____
Institution or Individual

_____
Street Address

_____
City/State/Zip

Phone #: _____

Fax # : _____

TO:

_____
Institution or Individual

_____
Street Address

_____
City/State/Zip

Phone #: _____

Fax # : _____

The purpose/need for the information is: _____
NOTE: Only information relevant to the purpose for which disclosure is sought may be disclosed.

Information to be disclosed:
☐ Medical Record
☐ Billing Record
☐ X-ray Films
☐ Other _____

Information to be disclosed verbally:
☐ Medical Information
☐ Lab and Xray Results
☐ Information by telephone
☐ Information on telephone voice mail

Dates of service to be disclosed:
☐ Specific Date:_____
☐ Range of Dates: _____
☐ Any and all dates
(relevant to the purpose/need)

Please allow 7-10 working days for paper records to be copied and sent

Disclosures Requiring Special Authorization
By marking any of the boxes below, I specifically authorize the use or disclosure of information containing these categories of highly confidential information:
□ Behavioral Health*
□ HIV/AIDS Testing or Treatment
□ Substance Abuse (Drug/Alcohol)
□ Sexually Transmitted Diseases

This authorization will expire one year from the date of signature unless a date or event prior to one year is specified:
_____ (Enter the date or event that you request this authorization to expire)

My signature below acknowledges that I understand that:

- If I refuse to authorize disclosure of this information, the following are the consequences (specify if any): _____
- I have the right to inspect or obtain a copy of the information to be disclosed.
- New Mexico and federal laws prohibit third parties from disclosing protected health information, especially mental health, developmental disability, and substance abuse treatment information. However, I understand that once Women's Health Services discloses my health information to the recipient, Women's Health Services cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and New Mexico law governing the use and disclosure of my health information.
- I may refuse to sign or, at any time, may revoke this Authorization for any reason, and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Women's Health Services.
- This Authorization will remain in effect until the term of this Authorization specified herein expires or I provide a written notice of revocation for this Authorization. A Notice of Revocation form can be obtained by contacting Women's Health Services' Medical Records Department. The revocation will be effective upon Women's Health Services' receipt and processing of my written revocation, however, the revocation will have no effect on any prior disclosures made in reliance of the Authorization.
- I have read and understand the terms of this Authorization. By my signature, I hereby, knowingly and voluntarily authorize Women's Health Services to use or disclose my health information in the manner described above.

_____ _____
Patient Signature Date Witness* Date

If the patient is a minor or is otherwise unable to sign this Authorization, the patient's Personal Representative must sign.

_____ _____
Authorized Personal Representative Date Relationship to Patient

_____
Witness* Date

**** Witness signature required for release of Behavioral Health information.***
NOTE: Any alteration or modification of this form will delay processing and provision of the requested protected health information.