San Juan Health and Wellness Center
1009 Ridgeway Place | Farmington, NM 87401
(505) 327-0002 phone | (505) 325-9443 fax

Authorization to Request / Release Information

Client Info

Name:_____

Address:_____

DoB:_____ SS#_____ Phone:_____

Release and/or Receive Information From

I authorize:

Facility:_____

Address: _____

_____

Phone#_____

Fax#_____

Release and/or receive Information To

I authorize:

Facility:_____

Address: _____

_____

Phone#_____

Fax#_____

Information to be released

- ❑ Medical information
- ❑ Psychiatric diagnosis and treatment
- ❑ Mental health diagnosis and treatment
- ❑ Substance use disorder diagnosis and treatment
- ❑ Other (specify) _____

Purpose of Release

- ❑ Continuation of Care
- ❑ Insurance
- ❑ Legal
- ❑ Personal/other (specify)

Time Span

Release:

- ❑ All of my records
- ❑ Progress notes and problem list
- ❑ Records limited to:

From: _____ To: _____

Authorization

If the information to be released pertains to the diagnosis and treatment of alcoholism and/or drug abuse, I understand that Federal Law 42 CFR Part 2 protects the confidentiality of the information. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I certify that this request has been made voluntarily. I understand this consent will expire upon_____, or if left blank, in one (1) year. I hereby release the provider/agency from any liability that may result from furnishing the information requested as authorized in the release. I understand that I may revoke this authorization at any time (except to the extent that the action has been taken to comply with it); I must do so in writing to the facility Privacy Officer or his/her designee. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected by the HIPAA Privacy Rule. I MAY REFUSE TO SIGN THIS AUTHORIZATION. A copy of this authorization is to be considered as valid as the original.

I understand that the information released may include a diagnosis or reference to the following condition (s): behavioral health services/psychiatric care; acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or drug and/or alcohol abuse.

Signature

By signing the Authorization, I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the Authorization.

_____Relationship:_____Date:_____

Client, (Parent or Guardian if client is a minor).

_____Date:_____

Witness