

HIPAA
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
MENTAL HEALTH RECORDS

Patient name: _____ **D.O.B.:** ____/____/____ **S.S.N.:** _____

Dates of Treatment: beginning _____ **through** _____
[relevant time period must be inserted]

AUTHORIZATION:

I, _____, authorize the disclosure of my protected health information as described herein.

1. I authorize the following person(s) and/or organization(s) to disclose the protected health information described in paragraph 3.

[individual medical provider name must be inserted]

2. I authorize the following person(s) and/or organization(s) to receive the protected health information described in paragraph 3.

[individual firm or lawyer must be inserted]

3. The records authorized to be released include:

☐ complete copy of medical records

☐ test results

☐ other

4. I expressly waive any laws, regulations and rules of ethics which might prevent any health care provider who has examined or treated me from disclosing my records pursuant to this Authorization.
5. The purpose of this Authorization relates to a legal action now pending in the United States District Court for the District of New Mexico.
6. I understand that I may revoke this Authorization at any time by sending a letter to the person or organization listed in paragraph one (1), except to the extent that such person(s) and/or organization(s) may have already taken action in reliance on this Authorization. If I do not sign, or if I later revoke, this Authorization, the services provided to me by such person or organization will not be affected in any way.
7. This Authorization expires one year from its date of execution.
8. THIS AUTHORIZATION DOES NOT PERMIT THE PERSON OR ORGANIZATION LISTED IN PARAGRAPH TWO (2) TO OBTAIN OR REQUEST FROM THE MEDICAL PROVIDER IDENTIFIED IN PARAGRAPH ONE (1) ORAL STATEMENTS, OPINIONS, INTERVIEWS OR REPORTS THAT ARE NOT ALREADY IN EXISTENCE.
9. Copying costs will be borne by the person or organization named in paragraph two (2).
10. A photocopy or facsimile of this Authorization is as valid as an original.
11. I understand that I have a right to examine the information to be disclosed, unless deemed that such disclosure is not in my best interest.
12. I understand that a potential exists for information that is disclosed pursuant to this Authorization to be subject to re-disclosure by the recipient and therefore be no longer protected by federal confidentiality rules.

SIGNATURE OF PATIENT OR
AUTHORIZED REPRESENTATIVE:

CAPACITY OF REPRESENTATIVE,
IF APPLICABLE:

DATE OF SIGNATURE:
