New Mexicare Inc.
dba
Guadalupe County Hospital

Authorization for Release of Medical Records and Psychiatric Records

Patient's Name:	Date of Birth:	Last 4 SSN:

I herby authorize New Mexicare Inc., dba Guadalupe County Hospital to release and disclose information in the form of _____ obtained in the course of my diagnosis and treatment at
(Specify: copy, visual inspection, oral communication)

_____ to the following person or institute:
(Specify: Service Area I.e. College Clinic, Med/Srg, etc.)

Mail,E-Mail, Fax to or pick up by:			
Address:	City:	State:	Zip:
Date of Treatment:	Reports of Information Requested:		
For the Purpose of:			

Note: Releasor acknowledges that records may include and/or contain reference to any or all of the following subjects and releasor, by (His/Her) signature directs that all the following material also be released and specified herin.

1. Any and all medical records/reports/documentary materials, tangible materials, which relate, in any way, to the alcohol/ substance abuse history, if any of_____.

2. Any and all medical records/reports/documentary materials, tangible materials, which relate, in and way, to the emotional/mental health/psychiatric condition, if any of_____.

3. Any and all medical records/reports/documentary materials, tangible materials, which relate, in and way, to the Human Immune Deficiency Virus (HIV) infection/ testing and/ or Acquired Immune Deficiency Syndrome (AIDS) if any, in the case of_____.

I understand that I may revoke this consent at any time, except to the extent that action has already been taken, and if not revoked sooner in writing, this consent will expire on the_____day of_____,20_____, or upon the happening of_____(Specify Condition or event). I understand that I have a right to examine and copy the information to be disclosed, unless deemed that such discloser is not in my best interest.

To The Receiving Party Of This Information:

This information has been disclosed to you from records protected by Federal rules (42-CFR, Part 2 and 42 -Usc-29dd) and NM Statues (431-19 and 24-2B-1) for the sole purpose stated in this consent.
Any other use of this information without the express written consent of the patient is prohibited. The Federal rules restrict use of this information to criminally investigate or persecute any alcohol or drug abuse patient.

I understand that although the above statement informs the recipient that is is against the law to further disclose my medical record information to any other person or institution without my written consent, I realize that _____ has no legal obligation or ability to limit disclosure of information by _____ (Person or Entity to whom information is to be released.

Patient Signature:		Date:
Signature of Patient's Legal Representative:	Relationship to Patient:	Date:
Witness Signature:		Date: