HIPAA
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient name: _____ D.O.B.: ___/___/___ S.S.N.: _____

Dates of Treatment: beginning _____ through _____.

AUTHORIZATION:

I, 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.

Santa Fe County (including its agents, employees) 102 Grant Avenue Santa Fe, NM 87501

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

3. The records authorized to be released include:

[ ] complete copy of medical records (excluding Test Results, HIV/AIDS, Sexually Transmitted Diseases, Mental or Behavioral Health, and Alcohol and/or Drug/Substance Abuse Treatment records)

[ ] Test Results

[ ] HIV/AIDS

[ ] Other Sexually Transmitted Diseases

[ ] Mental or Behavioral Health

[ ] Alcohol and/or Drug/Substance Abuse Treatment (Must provide an explicit description, as limited as possible, of what substance use disorder information may be disclosed)
_____
_____
_____

[ ] Other (Describe) _____

4. The purpose of the requested use or disclosure is:

   [ ] at the request of the individual

   [ ] other (describe) _____

5. I expressly waive any laws, regulations and rules of ethics which might prevent Santa Fe County, its agents and employees, from disclosing my health information including records pursuant to this Authorization.

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 or _____.

8. THIS AUTHORIZATION DOES NOT PERMIT THE PERSON OR ORGANIZATION LISTED IN PARAGRAPH TWO (2) TO OBTAIN OR REQUEST FROM SANTA FE COUNTY, ITS AGENTS AND EMPLOYEES (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 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.

12. Treatment, payment, enrollment or eligibility of benefits has not been conditioned on signature of this Authorization.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE: _____

CAPACITY OF REPRESENTATIVE IF APPLICABLE: _____

DATE OF SIGNATURE: _____