**Silver Health CARE, PC**
1600 East 32nd Street
Silver City, NM 88061
575.538.2981 - 575.388.3373 (fax)

***Please read and fill out BOTH sides completely!***

# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

| | | |
|---|---|---|
| Name of Patient: | | |
| Date of Birth: | SS#: | Medical Record #: |
| Daytime Phone: | Evening Phone: | |
| Address: | | |
| City: | State: | Zip Code: |

☐ I hereby authorize Silver Health CARE, PC to use or disclose my protected health information as indicated below to:

☐ I hereby authorize Silver Health CARE, PC to obtain my protected health information as indicated below from:

| | | |
|---|---|---|
| Name: | | |
| Daytime Phone: | Fax #: | |
| Address: | | |
| City: | State: | Zip Code: |

Information to be released:

**Indicate Dates**

**From:** _____

**To:** _____

- ☐ History & physical exam
- ☐ Lab report
- ☐ X-ray report
- ☐ Consultation report
- ☐ Other _____

Purpose of Disclosure:

- ☐ Changing physicians
- ☐ Continuing care
- ☐ At my (patient's) request
- ☐ Worker's Compensation
- ☐ Other _____
- ☐ Second Opinion
- ☐ Legal
- ☐ Insurance
- ☐ School

I understand that this health information may include genetic testing and/or STD-related information and/or information relating to diagnosis or treatment of psychiatric disorders and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

- ☐ Substance Abuse (including alcohol/drug abuse)
- ☐ Mental Health Assessment
- ☐ Mental Health Treatment & Summary
- ☐ Psychotherapy Notes
- ☐ Sexually transmitted disease including HIV/AIDS virus
- ☐ Genetic Testing, consultation and/or counseling

The confidentiality of this record is required under NM Code R.§16.10.17.8 as well as Title 42 of the United States Code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Signature of Patient or Legal Guardian _____ Date _____

1) I understand that this authorization will expire one year from date of signed request. A photocopy of this form will be considered as valid as the original.
2) I understand that this medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
3) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations. However, other state and federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

**Continued on other side**

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Continued…

5) I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
6) I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
7) I understand that I will get a copy of this form after I sign it. (See below for signature)

By signing below, I acknowledge that I have read and understand this Authorization.

**Cost per year for records for active SHC patients:**

Paper - First Request: No Charge
Second Request: First 15 pages $2.00 and
$ .25 each page thereafter.
CD - First Request: No charge
Second Request: $10.00.

Records sent to another health care facility: No charge.

**Please indicate if requesting** ☐ **CD or**
☐ **Paper**

Signature of Patient Date

OR

Signature of Parent/Legal Guardian/Authorized Person

AND

Relationship to Patient Date

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

*I understand that my medical record may contain reports, test results, and notes that only a health care practitioner can interpret. I understand that I should contact my health care practitioner regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Silver Health CARE liable for any misinterpretation of the information in my medical record as a result of not consulting my health care practitioner for the correct interpretation.*

_____

*Signature of Patient or Legal Representative* *Date*

_____

*Relationship to Patient (If Legal Representative)*

**FOR OFFICE USE ONLY**

| | | |
|---|---|---|
| Date Request Filled: | By: | |
| | | Account #: |
| Identification Presented: | | Fee Collected: |

**Continued on other side**