

NAME: _____

DOB: _____ **ID #:** _____

Authorization To Disclose And Receive Health Information

I hereby authorize Southwest Family Guidance Center & Institute to receive information from and disclose information to:

NAME: _____ **AND APPROPRIATE STAFF AT:** _____

ORGANIZATION: _____ **PHONE #:** _____

ADDRESS: _____ **FAX #:** _____

FOR THE PURPOSE OF: _____

INFORMATION TO BE DISCLOSED: *This authorization does not provide for the release of psychotherapy notes.*

- TREATMENT SUMMARY
- TREATMENT PLAN
- INITIAL ASSESSMENT
- CLINICAL ASSESSMENT

INITIALS _____ DISCHARGE DOCUMENTATION BILLING STATEMENT OTHER _____

COVERING THE PERIOD(S) FROM (DATE) _____ **TO** _____

OR FROM (DATE) _____ **UNTIL DISCHARGED FROM SWFGC.**

I AUTHORIZE THE FOLLOWING RELEASE OF INFORMATION:

- YES NO Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection or other sexually transmitted diseases. **INITIAL** _____
- YES NO Behavioral health services/psychiatric care **INITIAL** _____
- YES NO Treatment for alcohol and/or drug abuse **INITIAL** _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the agency privacy officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will remain in effect: until ; _____ or, until discharged from SWFGC. If no expiration date or event is otherwise listed here, I understand that this authorization will expire one year after the date it is signed.

_____ **INITIAL** I understand that under NMSA 1978 § 32A-6A-24, a child has a right to examine and copy confidential information about the child that is to be disclosed, the name or title of the proposed recipient of the information, and a description of the use that may be made of the information. Please check appropriate boxes below:

- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the in formation may not be protected by federal privacy laws or regulations.**
 - I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to obtain health care treatment.**
- OR **I choose not to disclose either my or my child’s health information.**

SIGNATURE OF PATIENT (IF 14 OR OVER) **DATE**

SIGNATURE OF PARENT, GUARDIAN, OR LEGAL REPRESENTATIVE **RELATIONSHIP TO PATIENT** **DATE**

PRINTED NAME OF SWFGC REPRESENTATIVE WITH CREDENTIALS **DATE**