Behavioral Medicine Associates, Inc.

1010 N. Virginia Ave., Roswell, NM 88201

Phone (575)623-9322 *Fax* (575)627-6339

AUTHORIZATION FOR USE OR RELEASE OF PROTECTED HEALTH INFORMATION REGARDING MEDICAL, PSYCHOLOGICAL, AND/OR SUBSTANCE ABUSE RECORDS

I hereby authorize: Behavioral Medicine Associates, Inc., 1010 N. Virginia Ave. Roswell, NM 88201
Phone: (575)623-9322 Fax: (575)627-6339

______To Receive or ______ Release health information and records obtained during the course of treatment of:
Purpose of this release: [ ] Continuity of Care [ ] Other: ____

Patient Name: ____ DOB: __________________ SSN: ______________________

The information is to be used or disclosed to/from the following persons or organizations:
Person/Entity Name: ____

Information to be used or disclosed: The information to be used or disclosed includes only those items checked below, with respect to services provided on or around (insert dates of service): ________________. If this line is left blank, the treatment dates covered by this authorization are from preadmission to discharge and claims resolution.

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. The information to be used or released includes:

___ Discharge Summary
___ Discharge Instructions
___ Psychiatric Evaluation
___ History and Physical Exam
___ Admissions Summary
___ Face Sheet

___ Medication Records
___ Assessments
___ Education Records
___ IEP & Diagnostic Testing
___ Psychological Evaluation/Testing
___ Other ___________________

___ Treatment Plans
___ Physician Progress Notes
___ Physician Orders
___ Consultation Reports
___ Verbal Communication with:
Name: ___________________
Relationship: _______________

- Expiration: I understand that unless I revoke the authorization earlier, this authorization will automatically expire 180 days from the date signed.
- Revocation: I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about the information already used or disclosed under this authorization.
- The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statues, Rules and the Regulations (including The New Mexico Mental Health and Development Disabilities Code; New Mexico Administrative Code; Emancipation of Minors Act: Title 42 of the code of Federal Regulations; and HIPPA).
- I understand that treatment and payment may not be a condition of this authorization.

Patient Signature: ____ Date: ________________________________
Parent/Legal Guardian: ____Date: ________________________________
Staff Member/Witness: ____Date: __________________________________