THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient/Employee Name: _____ **Date of Birth:** _____**Medical Record #:** _____

I hereby authorize the following provider **Name**_____

Address_____

to disclose/discuss information from my health record for the purpose of: EMPLOYER RETURN TO WORK EVALUATION.

Disclosure authorized to: __Employee Occupational Health Services Clinic
University of New Mexico, Albuquerque, NM 87131
Phone 505-272-8043 Fax 505-272-8044 .

2. Information to be disclosed:

[x] most recent visit/admission	[x] progress notes	[ ] school records
[x] history & physical exam	[x] laboratory tests	[x] psychological evaluation
[x] initial assessment	[x] x-ray reports	[x] physical therapy evaluation
[x] consultation reports	[x] pathology reports	[x] speech & language evaluation
[x] operative report	[x] ER record/outpatient log	[x] occupational therapy
[x] discharge summary	[ ] Billing	

[ ] Other (please specify) _____

Covering the period(s) of healthcare: from (date) _____ to (date) Today's date: _____

Title II of the Genetic Information Nondiscrimination Act (GINA) prohibits employers from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

3. I further authorize that this disclosure of health information will include information relating to (initial if applicable):

[ ] yes [ ] no acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, or other sexually transmitted diseases _____ initial
[X] yes [ ] no behavioral health services/psychiatric care _____ initial
[X] yes [ ] no treatment for alcohol and/or drug abuse _____ initial
[ ] yes [ ] no genetic test results and related patient information _____ initial

4. 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 Health Information Management Department. 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 expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date on which it was signed.

5. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

6. I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this Authorization and need not sign this Authorization to obtain health care treatment; and that if I authorize the disclosure of this health information, I have the right to examine and copy the information to be disclosed. A copy of this signed Authorization will be provided to me.

_____

Signature, Patient, or legal representative (Relationship to patient) (Date)

_____

Signature of Witness (Date) (Parent, if CPH/PFC&A patient over 14) (Date)

PROHIBITION OF REDISCLOSURE: Federal regulations (42 CFR Part 2) and State laws (NMSA 1978 §§ 43-1-19, 32A-6A-24, 24-2B-7 and 24-1-9.5) prohibit further disclosure of mental health or alcohol and/or drug abuse treatment information, and of the results of tests for HIV/AIDS and other sexually transmitted diseases to any person or agency without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or State laws.