THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER

AUTHORIZATION TO REQUEST HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____Medical Record #: _____

I hereby authorize the Employee Occupational Health Services clinic of the UNM Center for Occupational and Environmental Health Promotion to receive information from my health record.

Requested health care provider/medical facility:
Name: _____
Address and Telephone Number: _____

For the purpose of: [ ] **Catastrophic Leave application through UNM Human Resources**
[ ] **Other (please specify):_____**

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	

[x] Other (please specify) ___if clarification is necessary, the EOHS provider may discuss my medical health information with my health care providers_____

Covering the period(s) of health care: from (date) _____ to (date) _____
from (date) _____ to (date) _____

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

[ ] 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
[ ] 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.

E-mail as pdf to Sheila McKisson at smckisson@salud.unm.edu or Fax to 272-8044 (secured office), or send through Internal Mail to: Sheila McKisson, EOHS, MSC 10-5550