Perinatal Associates
of NEW MEXICO

Authorization For Use/Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of health information, about you.
Failure to provide all information requested may invalidate this Authorization.

PATIENTS NAME | DOB

I hereby authorize:

NAME

ADDRESS

CITY | STATE | ZIP

PHONE | FAX

To release to:

PERINATAL ASSOCITAES OF NEW MEXICO

201 CEDAR SE, SUITE 405

ALBUQUERQUE | NEW MEXICO | 87106

505-764-9535 | 505-843-9646

The following information:

A. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received

– OR –

☐ Only the following records or types of health information (including any dates):

B. I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information[1]

☐ HIV test results

☐ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE of requested use or discloser: ☐ Patient Request ☐ Other

PATIENT/GAURDIAN SIGNATURE | DATE

if signed by someone other than the patient, please state your relationship

WITNESS | DATE

[1] If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.