Compassionate Hearts, LLC
MEDICAL CANNABIS CARD ASSISTANCE™

Patients Helping Patients
obtain or renew their New Mexico Medical Cannabis Card

Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth: _____

Address:_____ City: _____ State: _____ Zip _____

Phone: _____ Email:_____

I. AUTHORIZATION

I authorize (***healthcare provider or practice name***) _____ to release my protected health information described below to **Compassionate Hearts, LLC**.

Providers Phone:_____ Providers Fax:._____

II. EFFECTIVE PERIOD (*Dates of Service*)

This authorization for release of information covers the period of healthcare from:

A. ❑ _____ to _____. **OR** B. ❑ All past, present, and future periods

III. EXTENT OF AUTHORIZATION

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. This authorization shall be in force and effect until two years from date of execution at which this authorization expires.

Purpose of disclosed: Obtain or renew patient New Mexico medical cannabis card.

I understand the following: See CFR § 164.508(c)(2)(i-iii)
(1.) I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance on this authorization. (2.) The information released in this authorization may be re-disclosed to other parties.

❑ Current Problem List ❑ Chart / Progress Notes ❑ Diagnosis ❑ Other_____

❑ HIV / AIDS Related Information ❑ Drug / Alcohol Related Information ❑ Psychological / Psychiatric Evaluation

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Name and Relationship of Legal Representative to Patient Date

_____ _____
Witness Signature Date

FOR OFFICE USE ONLY:_____

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed below) to arrange the return of the information and all copies.