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*) _____ to release my protected health information described below to Compassionate Hearts, LLC.

Providers Phone:_____ Providers Fax:._____

II. EFFECTIVE PERIOD

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 authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases including HIV or AIDS). **PLEASE EXCLUDE ANY AND ALL LAB WORK.**

- ☑ DIAGNOSIS
- ☑ PROGRESS NOTES
- ☑ HISTORY & PHYSICAL
- ❑ OTHER: _____

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY:_____