



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: _____

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