

SPECIAL AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

From the San Juan Health Partners clinics listed below - **check one box**

Aztec Family Practice

Neurology Practice

Patient ID Verified: Y N

Internal Medicine and Pulmonology

Spine Center

Verified by: _____

Heart Center

Urology Clinic

Date: _____

General Surgery

Barkman / Kelly

To maintain confidentiality, the patient or legal representative must complete bold items, sign this form and present a picture ID

I hereby authorize you to disclose the following information from the medical records of:

PATIENT NAME: _____

DATE OF BIRTH: _____ SSN: XXX-XX- _____ (Last 4 only)

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ TELEPHONE: _____

THIS INFORMATION IS TO BE DISCLOSED TO:

Compassionate Hearts, LLC
106 S. Main Aztec, NM 87410
Phone: 505-334-1994 Fax: 505-334-1999

****You have the right to restrict information. The information below will not be disclosed unless you check the box.****

Chart / Progress Notes

Current Problem List

Other: _____

TIME PERIOD OF REQUESTED INFORMATION:

FROM: _____ TO: _____

or:

- 1 year of records
 2 years of records
 3 years of records

Beginning on: _____

**** The box below must also be filled out and separate signature is required.****

HIV/AIDS Related information

Psychological/Psychiatric Evaluation

Drug/Alcohol Related Information

Not applicable

REQUIRES ADDITIONAL SIGNATURE _____

PURPOSE OF DISCLOSURE

To obtain or renew NM Medical Cannabis Card Other: (Please explain) _____

I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. It is further understood that the information disclosed is for the purpose stated above and may not be provided in whole or in part to any other agency, organization or person. This information has been disclosed to you from records whose confidentiality is protected by State Law. The State Law prohibits you from making further disclosure of such information without specific written consent of the person to whom the information pertains or is otherwise permitted by State Law.

Signature of patient or legal representative

Date

Relationship to Patient

Witnessed by (Signature)

(Print Name)

This consent will expire 6 months after date of signature.