SPECIAL AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

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

- ❑ Behavioral Health
- ❑ Family Medicine, Aztec
- ❑ Family Medicine, Farmington
- ❑ Gastroenterology
- ❑ General Surgery
- ❑ Heart Center
- ❑ Internal Medicine & Pulmonology
- ❑ Neurology Practice
- ❑ Pediatrics
- ❑ Spine Center
- ❑ Urology Clinic
- ❑ Dr Gayle Riley

Patient ID Verified: Y N

Verified by: _____

Date: _____

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
408 S. Park Ave., 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.*

HIM102017

SJHP facility use only: MR Number: _____