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. ❑ ALL RECORDS, B. ❑ from _____ to _____ , C. ❑ Other _____

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.

I understand 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. The information released in this authorization may be re-disclosed to other parties.

Specification of the date, event, or condition upon which this consent expires_____.

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

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

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

~ PLEASE DO NOT SEND ANY LAB WORK RESULTS ~

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Name and Relationship of Legal Representative to Patient Date

_____ _____
Witness Signature – **ONLY** if patient unable to sign for themselves. Date