



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

Confidentiality Notice: This information contained in this correspondence is confidential and is the property of the sender. The information is privileged and is intended for the confidential use of the individual(s) or entity(ies) specified above. If you are not the intended recipient, be advised that the law prohibits any unauthorized disclosure, copying, distribution or taking of any action based on the contents of this information. If you have received this transmission in error, please notify us immediately by telephone or return email. This transmission may accompany a disclosure of information concerning a client in alcohol/drug substance abuse treatment, made to you with the consent of said client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug substance abuse client.