Southwest Family Guidance Center & Institute

Authorization to Disclose and Receive Health Information

CLIENT NAME: _____ DOB: _____

I hereby authorize the Southwest Family Guidance Center and Institute to receive information from and disclose information to:

Name: _____ and appropriate staff at:

Organization: _____ Phone #:_____

Address: _____ Fax #: _____

FOR THE PURPOSE OF: _____

Information to be disclosed: ☐Most recent visit ☐Progress Notes ☐Initial Assessment
☐Psychological Evaluation ☐Discharge ☐Other _____

_____(initial) Covering the period(s) from (date) _____to _____ **or**
from (date) _____until discharged from SWFGC&I.

I authorize the following release of information;

☐ Yes ☐No Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection or other sexually transmitted diseases. _____ initial

☐ Yes ☐No Behavioral health services/psychiatric care _____ initial

☐ Yes ☐No Treatment for alcohol and/or drug abuse _____ initial

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the agency privacy officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will remain in effect: ☐ until _____; **or**, ☐ until discharged from SWFGC&I.

_____ (initial) I understand that under NMSA 1978 § 32A-6A-24, a child has a right to examine and copy confidential information about the child that is to be disclosed, the name or title of the proposed recipient of the information, and a description of the use that may be made of the information.

Please check appropriate boxes below:

☐ **I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations**.

☐ **I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to obtain health care treatment.**

☐ **I choose not to disclose either my or my child's health information.**

_____

Signature, Patient (if 14 or over) or legal representative (Relationship to patient) Date

_____

Signature of Parent or Guardian (if different than above) Date

_____

Printed name of SWFGC representative with Credentials Date