SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

**NAME:** _____

**DOB:** _____ **ID #:** _____

# Authorization To Disclose And Receive Health Information

I hereby authorize Southwest Family Guidance Center & 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:** *Note: This authorization does not provide for the release of psychotherapy notes.*

_____ ☐ **TREATMENT SUMMARY** ☐ **TREATMENT PLAN** ☐ **INITIAL ASSESSMENT** ☐ **CLINICAL ASSESSMENT**

*INITIAL* ☐ **DISCHARGE DOCUMENTATION** ☐ **OTHER** _____

**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 OF PATIENT (IF 14 OR OVER)** **DATE**

_____ _____ _____
**SIGNATURE OF PARENT, GUARDIAN, OR LEGAL REPRESENTATIVE** **RELATIONSHIP TO PATIENT** **DATE**

_____ _____
**PRINTED NAME OF SWFGC REPRESENTATIVE WITH CREDENTIALS** **DATE**