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: *This authorization does not provide for the release of psychotherapy notes.*

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

☐ **DISCHARGE DOCUMENTATION** ☐ **BILLING STATEMENT** ☐ **OTHER** ______________

______ *INITIALS*

COVERING THE PERIOD(S) FROM *(DATE)* ______________ **TO** ______________

OR FROM *(DATE)* ______________ **UNTIL DISCHARGED FROM SWFGC.**

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. If no expiration date or event is otherwise listed here, I understand that this authorization will expire one year after the date it is signed.

______ *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 in formation 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.**

OR ☐ **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**