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.*

_____ *INITIAL*

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