

**AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL CLIENT INFORMATION**

(Please indicate applicable division)

MESA MENTAL HEALTH

CORPORATE HEALTH RESOURCES

I, (please print) \_\_\_\_\_, hereby authorize the above-identified division of Mesa Mental Health Professionals, P.C. to:

**RELEASE**

**OBTAIN**

THE INFORMATION DESIGNATED BELOW FOR:

(Client name) \_\_\_\_\_, SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

**PERTAINING TO:**

(check all that apply)

**MENTAL HEALTH**

**EAP**

**HIV/AIDS**

**SUBSTANCE ABUSE**

**SEXUALLY TRANSMITTED DISEASES**

Please indicate records desired

**MENTAL HEALTH**

**MEDICAL**

**SCHOOL**

**VERBAL ONLY**

**EAP**

**COMPLETE RECORD**

**OTHER**

**DATES from:** \_\_\_\_\_

**to:** \_\_\_\_\_

**TO**

**FROM**

THE FOLLOWING ORGANIZATION/INDIVIDUAL

\_\_\_\_\_  
Name of Individual or Facility/Organization

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Phone Number

The information will be used for the following purpose(s) \_\_\_\_\_

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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. If not revoked sooner in writing, this consent will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_, or on the following event or condition:\_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire in one year. A photocopy of this authorization that contains my signature shall be considered as effective and as valid as the original and shall be honored by those to whom it is provided. I release Mesa Mental Health Professionals, P.C. from liability and claims of any nature pertaining to the disclosure of the health information identified in this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I have the right to examine and copy the information to be disclosed, unless deemed that such disclosure is not in my best interest. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Privacy Officer at the address below.

\_\_\_\_\_  
Patient Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Guardian/Legal Representative Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The 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. Federal regulations also restrict any use or disclosure of information to criminally investigate or prosecute any alcohol or drug abuse client.

**PLEASE DIRECT ANY CORRESPONDENCE TO:**

MESA MENTAL HEALTH PROFESSIONALS, P.C.

ATTN: PRIVACY OFFICER/Medical Records

PO BOX 90607

ALBUQUERQUE, NM 87199-0607