Desert Wise • 1201 Eubank Blvd NE, Ste. 1 • Albuquerque, NM 87112

Authorization for the Release of Patient Information Pursuant to 45 CFR § 164.508

- In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your written consent is required before disclosure of your personal health information.
- You have the right to inspect and receive a copy of your own protected health information to be used or disclosed, in accordance with the requirements of the Privacy Act and 45 CFR § 164.524.
- Any information shared pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA privacy rule.
- This request is valid for one year from the date of your signature, unless otherwise specified below or unless you otherwise revoke the request in writing. Written requests for revocation can be submitted at any time and must include your signature and the date.
- If you have any questions or concerns, please talk to your provider before completing this form. Completion and submission of this form means you do not have any remaining questions or concerns.

I. Patient information:

Patient Name			
Street Address			
City, State, Zip Code			
Telephone			
DOB		Last 4 of SSN	

II. Entity you are requesting records or information from:

Provider Name	
Agency	Desert Wise
Street Address	1201 Eubank Blvd NE, Ste 1
City, State and Zip Code	Albuquerque, NM 87112
Telephone	505-361-1957

I authorize and request the disclosure of all protected information. I expressly request that the designated record custodian (i.e., the provider and/or agency listed above in section II) disclose full and complete protected medical/mental health information, as indicated below:

- ☐ All mental health records, meaning every page in my record, including, but not limited to: office notes, history, consultation notes, inpatient/outpatient/emergency room treatment, clinical charts/records, assessment/testing reports, progress notes, status reports, treatment plans, all forms of correspondence, questionnaires/histories, and records received from other entities.
- ☐ Mental health progress notes for the following dates of service only: _____ to _____
- ☐ Billing statements for the following dates of service only: _____ to _____
- ☐ Other (specify): _____

III. Protected and Sensitive Information

Certain information you are requesting cannot be released without specific authorization. Please initial below if you agree to release the following:

____ I recognize that the information disclosed may contain MENTAL HEALTH information, which is protected by federal and state law. I specifically consent to the disclosure of such information.

____ I recognize that the information disclosed may contain DRUG/ALCOHOL information, which is protected by federal and state law. I specifically consent to the disclosure of such information.

IV. Entity you are releasing records or information to:

Person or Provider	
Agency (if applicable)	
Street Address	
City, State and Zip Code	
Telephone	

V. Period of Authorization

Authorization Start Date: _____ Authorization Expiration: ◯ Date _____ **OR** ◯ Action Completed

Signature: _____ Date: _____

Relationship to patient (if other than self): _____