Bosque Women's Care
5150 San Francisco Rd NE
Albuquerque NM 87109
Phone 505-847-4100
Fax 505-847-4945
www.bosquewomenscare.com

Authorization for the Use and Disclosure of Individually Identifiable Protected Health Information

Patient Name _______________________________________ Date of Birth _________________________

Address ________________________________ City ____________________ St ________ Zip _________

Phone (home) _____________________ (cell) __________________ (work) ______________________

Social Security number _______________________________ email _______________________________

1. I authorize the use or disclosure of the above named individual's health information as described below. 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.

2. **Request Records From:** (Individual or organization authorized to make the disclosure)

____ phone ________________ fax______________

3. **Release Records To:** (Information listed in #4 below may be disclosed to the following individual or organization)

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Albuquerque NM 87109
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4. Specific description of information to be used or disclosed: ______ Entire Record
Specify:____ from (date) __________ to (date) ______________
Specify:____ from (date) __________ to (date) ______________

5. The information that will be disclosed will be used for the following purposes:
____

6. I understand that this authorization may include the release of information relating to:
Sexually transmitted diseases (STD) Initials of patient __________
Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) Initials of patient __________
Developmental disabilities or behavioral and mental health services or conditions Initials of patient__________
Treatment for alcohol and drug use Initials of patient __________

7. I hereby expressly waive any laws, regulations or rules of ethics that might prevent any hospital, doctor, psychotherapist, laboratory or other health care provider who has examined or treated the above patient in a professional capacity or otherwise, from releasing such documents. Initials of patient __________

8. I understand I have the right to revoke this authorization at any time by notifying the individual or organization that is authorized to make the disclosure, in writing, except to the extent that action has been taken in reliance

on this authorization; or if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest the claim or the policy itself. Unless otherwise revoked, this authorization ***will expire on the following date, event or condition***: ___________________________________.
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

9. 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 I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that I have a right to receive a notice of privacy from any health care provider that discloses the above protected health information.

10. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

____

Signature of Patient (or Patient's Representative) Date

____

Relationship to Patient (if signed by Patient's Representative)