

**Authorization for Release of Health Information**

Aggie Health & Wellness Center

PO Box 30001, MSC 3529

Las Cruces, NM 88003

(575) 646-1512

(575) 646-6428 (fax)

|  |
| --- |
| Patient/Client Name |
| Date of Birth (MM/DD/YR) | Aggie ID# | Phone Number |
| Mailing Address |
| City | State | Zip |
| Person/Organization **Providing** Information: | Person/Organization **Receiving** Information |
| Mailing Address, City, State, Zip | Mailing Address, City, State, Zip |
| Describe the information to be released. Include dates of service and type of service: |
| Describe the purpose of this request: |
| **Initial** | **Please initial understanding of all statements** |
|  | I understand the **medical and mental health records** described above may include sensitive information related to medical and psychological diagnosis and treatment, and include sensitive information related to workers comp injuries, HIV/AIDS and STI infection/treatment, and drug and alcohol use or abuse information. |
|  | The Aggie Health & Wellness Center will not condition my treatment, payment, or enrollment in a health plan on whether I provide authorization for the above request. |
|  | This authorization shall become effective immediately and will expire on the following date, event, condition, or in six (6) months from the date signed. **Enter alternative date if requested:** |
|  | I understand that I may receive a copy of this form if requested. I may see and request a copy of the information described to be released on this form if I ask for it. I agree to pay any fees associated with the copying of records. I also understand that any review of original health (medical and psychological) will be supervised. |
|  | I understand that I have the right to revoke this authorization, in writing received at the address below. I understand that the revocation will not apply to health information that has already been released in response to this authorization. |
|  | I understand that the authorized health information may be electronically communicated. |
| **Authorization for Release of Information** |
|  | I authorize the NMSU Aggie Health & Wellness Center to **obtain information** from the above listed person/organization. |
|  | I authorize the NMSU Aggie Health & Wellness Center to **release information** from the above listed person/organization. |
| **SPECIFIC INFORMATION AUTHORIZED** |
|  | Mental Health Records |  | Medical Records |
|  | Alcohol & Drug Treatment Services |  | HIV, AIDS, or other sexually transmitted infection |
|  | Workers Comp Injury |  |  |
|  | Other |

I certify that this request was made voluntarily and that the information given is accurate to the best of my knowledge.

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Signature of patient/client or authorized legal representative Date

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Witness Date

**NMSU AGGIE HEALTH & WELLNESS CENTER, P.O. BOX 30001 MSC 3529, Las Cruces, NM 88003**

**Instructions for the Completion of Authorization for Release of Health Information**

The authorization may be printed and used for your convenience. This form may also be obtained at the Front Desk of the NMSU Aggie Health & Wellness Center (AHWC). A patient/client may use this form to request that their AHWC records be sent to another medical or mental healthcare provider, or for purposes authorized by the patient/client.

**Please be careful to read and complete all sections of the form.**

No charges are associated with copying of records when the records are transferred directly to another medical or mental healthcare provider or facility.

**Mail, Fax or Email completed form to:**

 NMSU Aggie Health & Wellness Center

 PO Box 30001 MSC 3529

 Las Cruces, NM 88003-8001

campus\_health@nmsu.edu

(Fax) 575-646-6428

If you have any questions regarding the form, obtaining the records, or for clarification of charges, please call 575-646-1512.