DE BACA FAMILY PRACTICE DENTAL CLINIC
PO BOX 349
546 N 10TH STREET
FORT SUMNER NM 88119
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION MEDICAL RECORDS

Patient Name:	Telephone Number:
Date of Birth:	Address:

This Authorization related to **DENTAL** records and treatment beginning _____through_____.

I, or my authorized representative (named below), authorize the disclosure of my protected health information as described herein.

Authorized Representative:
Name: _____ DOB_____
Relationship:_____
Authorized Representatives status:_____
Duration given for Authorized Representative: Enter Dates_____

1. I authorize the following person(s) and/or organization(s) to **disclose** my protected health information:

2. I authorize the following person(s) and/ or organization(s) to **receive** my protected health information:

3. This authorization may include disclosure of information relating to ALCOHOL and DRUG treatment records, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH records (except Psychotherapy notes), and CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), or HUMAN IMMUNODEFICIENCY VIRUS (HIV) related information, if I place MY INITIALS in the appropriate section. In the event the health information described includes any of these types of information, and I initial, that I specifically authorize release of such information to the person(s) and/or Organization(s) identified.
4. I understand that signing this authorization is voluntary, my treatment, payments, insurance or appointments will not be conditioned upon my authorization of disclosure.
5. The recipient might re-disclose information disclosed to them under this authorization, and Federal or State law may no longer protect the re-disclosure. However, except in limited circumstances, re-disclosure of HIV related records, sexually transmitted disease treatment, genetic testing or mental health and developmental disability treatment id

prohibited by New Mexico law unless you authorize re-disclosure in writing. I understand that I have a right to request a list of people/organizations who may receive or use my HIV related information without my authorization.
6. This authorization does not authorize you to disclose my protected health information and insurance records with anyone other than listed in Section 2.

7. Specific protected health information **to be released**: **MUST INITIAL**

Patient DENTAL & treatment histories (excluding those which contain Drug & Alcohol Testing/Treatment, HIV, Behavioral Health, STD's and Genetic testing. (unless noted and initialed below)	
Provider Notes (excluding Psychotherapy Notes)	
Test Results (excluding HIV/AIDS, STD's, Genetic Testing or Alcohol/Drug Testing	
Radiology Studies and copies of films	
Referrals	
Consults	
Billing Records and Insurance Records	

By initialing below, I expressly authorize release of any records in my protected health information medical record that relates to the following conditions: (if I have not initialed the following, the provider is not authorized to disclose).

Alcohol & Drug Treatment Records (excluding notes and treatment programs subject to 42 CFR part 2)	
HIV/ AIDS Related records	
Other:	

*This authorization will be in effect for **one year** from the date signed, unless you indicate a shorter period. _____.

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

Signature of Patient_____Date_____

Signature of Authorized Representative_____Date_____

Witness Signature_____Date_____

REV 04/11/18