New Mexico Retiree Health Care Authority
Authorization Form for Release of Protected Health Information (PHI)

I, _____, hereby authorize the use or disclosure of the health information as described in this authorization.

1. Specific person/organization or class of persons authorized to **provide** the information:

2. Specific person/organization or class of persons authorized to **receive** and use the information (*insert name, title, address fax, phone and e-mail if possible)*:

3. Specific **description of the information to be used or disclosed** (*Include names of individuals to whom the information pertains such as a minor child, description of information and dates, as appropriate*):

4. **Purpose of the request** (*Check one*): ☐ At the request of the individual signing this form.

☐ Other: _____

5. **Right to Revoke:** I understand that this authorization is voluntary and that I have the right to take back (revoke) this authorization at any time by notifying the Privacy Officer (in writing) at the address noted below. I understand that such a revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.

6. **I understand that after this information is disclosed, Federal law might not protect it and the recipient might disclose it again**.

7. I understand that I am entitled to receive a copy of this authorization and the information described on this form if I ask for it.

8. I understand that this authorization will expire as indicated here:

☐ One year from the date of this authorization.
☐ On the following date: _____, 20___.

9. The Plan will not condition treatment, payment, enrollment, or eligibility for benefits on receipt of an authorization.

10. If this authorization is **for marketing purposes**, this Plan is not receiving financial remuneration (payment) from the third party whose service or item is being marketed. If the authorization is **for the sale of Protected Health Information**, the disclosure will not result in remuneration (payment) to the Plan.

_____ _____
Signature of Individual Date

or

_____ _____
Signature of Personal Representative Date

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization form on the basis of: ☐ a signed Personal Representative Form; or ☐ Other _____

Acknowledgement by the Privacy Officer: _____ Date: _____, 20___

Once completed, please return this form to the:

Privacy Officer for the NMRHCA
Interim: Jess Biggs, Communications Director
6300 Jefferson St NE, Suite 150, Albuquerque, NM 87109
Telephone: 505-222-6413 Email: RHCA.Security@state.nm.us