STATE OF NEW MEXICO

COUNTY OF BERNALILLO

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Last Name, First Name, Middle Initial	Date of Birth (Mo/Day/Year)	Master ID

SECTION I. ENTITIES AUTHORIZED TO SHARE PROTECTED HEALTH INFORMATION

I hereby authorize the Bernalillo County Department of Behavioral Health Services (DBHS), the Bernalillo County Metropolitan Detention Center (MDC), and the University of New Mexico Hospital (UNMH) to release, disclose, use, receive and/or exchange among them my Protected Health Information (PHI) for the purpose of coordinating my medical and/or behavioral health treatment, or for providing me with social services including housing, government benefits, food, clothing, shelter, education, and/or employment. Additionally, I likewise authorize the release and exchange of information described above with the following:

Initial next to each provider with whom you authorize release of information.

— Presbyterian Hospital

— Lovelace Health Systems

— Recovery Services of New Mexico (RSONM)

— Metropolitan Detention Center Medical and Mental Health Contractor

— Law Offices of the Public Defender (LOPD)

— Metro Competency Court Case Manager

— Albuquerque Health Care for the Homeless

— ABQ StreetConnect/Heading Home

— New Mexico Coalition to End Homelessness and the New Mexico Homeless Management Information System (HMIS)

— HopeWorks/St. Martin's Hospitality Center

— First Nations Community HealthSource (FNCH)

— Mobile Crisis Team (MCT) Behavioral Health Clinician (BCSO/BCFD/APD)

— Albuquerque Community Safety (ACS) Dept. – Community Safety Responders

— Managed Care Organizations:

- Blue Cross Blue Shield of New Mexico
- Presbyterian Health Plan
- Western Sky Community Care

SECTION II. DESCRIPTION OF PROTECTED HEALTH INFORMATION

I permit the entities listed in Section I and those specified in Section V, if any, to share information in my files and to discuss my needs, my services and my treatment with each other. This may include information related to my care or treatment; medical and pharmacy records; information related to my application for, enrollment in, and eligibility for health care and social services; information about the benefits I receive or that I may be

eligible to receive and claims that seek payment for these benefits; and other information necessary to coordinate my care, my services and my treatment.

By signing this Authorization, I specifically permit the entities listed in Section I and those specified in Section V, if any, to share my health information that relates to the following types of services I receive (if any):

- Physical Health
- Behavioral Health
- Drug abuse diagnosis, treatment, prognosis, or referral
- Social Services

This authorization does not include psychotherapy notes.

SECTION III. EXPIRATION OF AUTHORIZATION

This Authorization will expire _____, unless revoked prior to this date. If no other date is set forth herein, the authorization will expire one (1) year from the date of signature.

If and when a Revocation of Authorization is received, the Bernalillo County Department of Behavioral Health Services will cancel the Authorization, effective immediately.

SECTION IV. OTHER IMPORTANT INFORMATION

1. I have a right to receive a copy of this Authorization. A copy of this Authorization is as valid as the original.

2. I have the right to refuse to sign this Authorization and remain eligible to receive treatment or services from any of the providers listed in Section I or specified in Section V.

3. I have the right to revoke this Authorization in writing prior to the expiration date listed in Section III. Depending on when I elect to revoke this Authorization, authorized entities listed herein may have already shared some or all available PHI prior to receiving notice of revocation. I may use the Revocation of Authorization below to terminate this Authorization.

   Mail or deliver the Revocation to:
   Special Projects Coordinator-Transition Planning
   Resource Reentry Center
   Bernalillo County Department of Behavioral Health Services
   401 Roma Ave. NW, Albuquerque, NM 87102

4. If my Protected Health Information includes information about mental health or developmental disability, I have the right to examine and copy that information.

5. For more information, contact the Bernalillo County Department of Behavioral Health Services at: (505) 468-7832 or RRC@bernco.gov.

SECTION V. OTHER SPECIFIED ENTITIES AUTHORIZED TO SHARE INFORMATION

The entities listed below are additionally authorized to release, disclose, use, receive and/or exchange Protected Health Information under this Universal Release Form.

Entity Name	Address
1.	
2.	
3.	
4.	
5.	

SECTION VI. AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

CLIENT OR CLIENT'S LEGAL REPRESENTATIVE

_____
Printed Name

_____ _____/_____/_____
Signature Month Day Year

If signed by Client's Legal Representative, state relationship and authority to do so:

_____
_____
_____

WITNESS

_____ _____
Printed Name Agency Name

_____ _____
Agency Address Phone Number

_____ _____/_____/_____
Signature Month Day Year

REVOCATION OF AUTHORIZATION

I wish to revoke my authorization, effective as of the date below.

CLIENT OR CLIENT'S LEGAL REPRESENTATIVE

_____
Printed Name

_____ _____/_____/_____
Signature Month Day Year

WITNESS

_____ _____
Printed Name Agency Name

_____ _____
Agency Address Phone Number

_____ _____/_____/_____
Signature Month Day Year

Mail or deliver the Revocation to:
Special Projects Coordinator-Transition Planning
Resource Reentry Center
Bernalillo County Department of Behavioral Health Services
401 Roma Ave. NW, Albuquerque, NM 87102