

**Authorization for Disclosure, Use or
 Receipt of Protected Health Information**

You have the right to refuse to sign this authorization. Mesilla Valley Hospital will not withhold treatment, Medicaid benefits, or payment processing if you refuse to sign this authorization. You will receive a copy of this signed authorization.

Patient Name: _____ DOB: _____ SS# _____

Dates of Service: _____ From _____ (fill in Admission date) until 180 days after discharge

I authorize the designated staff at **Mesilla Valley Hospital**

to disclose/use/receive the following protected health information about me:

- | | | |
|--|--------------------------------------|-------------------------|
| _____ Discharge Summary | _____ School Records | _____ After Care Packet |
| _____ Admission Psychiatric Evaluation | _____ Treatment Plans | _____ Entire Record |
| _____ History and Physical | _____ Labs, X-ray, EEG, EKG | _____ Other |
| _____ Psychological Testing | _____ Verbal Exchange of Information | |
| _____ Assessments | _____ Referral Instructions | |

The facility's designated staff may disclose to/ receive from: _____

(Name of person, organization, or facility)

Address: _____

Phone-Fax: _____

Please Check One of the Following:

I understand that the information to be disclosed pursuant to this Authorization may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), even though I am protected by Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records, 42 CFR Part 2 and applicable state laws protecting the confidentiality of AIDS/HIV information. I specifically authorize that any sensitive information regarding HIV/AIDS, may be used by or disclosed to the above referenced recipients.

I do not authorize the release of HIV/AIDS information.

The disclosure is for the following purpose(s):

- | | |
|--|---|
| _____ To coordinate my discharge planning/placement | _____ To assist in my educational placement |
| _____ At my request | _____ To assist in additional funding |
| _____ To discuss with my family the care and treatment I receive | |
| _____ Other (Specify) _____ | |

Note: If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.

Note: If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information disclosed/used/received may contain references about you and your family. You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the organization or facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practice. The authorization will expire in 180 days after it was signed.

Expiration Date: This authorization will expire 180 days after the date of the authorization unless otherwise specified.

 Patient Signature (Required if 14 yrs or older)

 Date

 Parent/Guardian/Authorized Representative

 Relationship to Patient

 Date

 Witness

 Date

 Witness

 Date

Physician Signature

Deemed Detrimental to Patient

This Release is _____ Approved