MESILLA VALLEY HOSPITAL

3751 Del Rey Blvd , Las Cruces NM 88012
(575)382-3500 Fax: (575)382-4904

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:_____

Dates of Service:_____ (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
_____Admission Psychiatric Evaluation
_____History and Physical
_____Psychological Testing
_____Assessments
_____School Records
_____Treatment Plans
_____ Labs, X-ray, EEG, EKG
_____Verbal Exchange of Information
_____Referral Instructions
_____ After Care Packet
_____Other

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
_____At my request
_____To discuss with my family the care and treatment I receive
_____Other (Specify)_____
_____To assist in my educational placement
_____To assist in additional funding

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