AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Patient/Student Name: _____ Date of Birth: _____

Social Security or Student Identification Number: _____

COMPLETE ALL SECTIONS, DATE, AND SIGN

I, (print name) _____, hereby voluntarily authorize New Mexico Highlands University to have access to information related to mental/behavioral health services I am receiving from _____and/or other mental/behavioral health care providers.

The information is to be DISCLOSED BY: (Student's Counselor:)	**The information is to PROVIDED TO**: New Mexico Highlands University
NAME OF PERSON/ORGANIZATION/FACILITY	**NAME OF PERSON/ORGANIZATION/FACILITY** Pamela Trujillo, Behavioral Health Counselor Kimberly Blea, Chair, Behavioral Intervention and Support Team
Telephone Number:	**Telephone Number:** Pamela Trujillo 505-454-3218; Kimberly Blea 505-454-3445
ADDRESS	**ADDRESS** NMHU, PO Box 9000,
CITY/STATE/ZIP CODE	**CITY/STATE/ZIP CODE** Las Vegas, NM 87701

This protected health information is being used or disclosed for the following purposes:

Compliance with treatment plan and/or compliance with prescribed medication. The university is not requesting specific information regarding diagnoses or types of medication prescribed._

The information to be disclosed from my health record:

___ Entire Record (except those records pertaining to the areas excluded below)
___ Only information related to (specify)
___ Only information created during the following period of time: From To
___ Other (specify)

The information NOT to be disclosed from my health record:

_____

This authorization shall be in force and effect for one year from the date of my signature, unless I have specified a different expiration date or expiration event [specify the date/event that relates to the patient or the purpose of the use or disclosure] __Graduation from NM Highlands University_____

Enter if different from one year after the date below

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the parties, except to the extent that the university has

relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal or state law, and to refuse to sign this authorization.

Signature of Patient	Date	Name of Patient	Date