



Authorization for Release of Protected Health Information

Date: _____ Name of Client: _____ DOB: _____

I hereby authorize Desert View Family Counseling, 6100 E. Main St., Farmington, NM 87402 to

- disclose to the following: obtain from the following:

Name of Agency Name of Contact

Address, City, State, Zip Phone Fax

The following information:

- Mental Health Assessment Substance Abuse Assessment
Treatment Plan Diagnosis
Treatment Recommendations Attendance & Progress (Tracking)
Progress Notes (Consult with Therapist first) Discharge Summary
Lab Results
Other:

The information to be released is for the following purposes:

- Evaluation Treatment Compliance Discharge Planning
Other:

I understand that this consent authorizes the release of information on an ongoing basis. I understand that I may revoke this consent at any time. I understand that treatment does not depend on whether or not I sign this consent. This consent is valid for a period of _____. (If no period is specified, the consent is valid for one year.) I understand I have the right to examine and copy the information disclosed, provided the clinician believes it is in the patient's best interest.

Client Signature Date

Parent / Guardian Signature (required if client is 14 years old or younger) Date

Witness Date

ONLY SIGN BELOW IF YOU WANT TO REVOKE THIS CONSENT TO RELEASE INFORMATION!
I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures.
Client Signature Date

Prohibition of Redislosure: Federal Law (42CFR, Part 2) and State regulations (32A-6-15 NMSA 1978 and 24-2B-7, NMSA 1978) prohibit further disclosure of this information to any person or agency without securing another proper written authorization for that purpose.