AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL PATIENT INFORMATION

I,_____, hereby authorize Michael R. Rodriguez, Ph.D., 3900 Juan Tabo, NE, Suite 4, Albuquerque, NM 87111 (505) 275-6405 to_____ release _____ obtain the following, to include but not limited to, information relating to mental condition, alcohol and/or drug abuse.

Please check all appropriate items and specify which materials are desired:

_____Confidential mental health records
_____ Test Results: Psychological_____
Medical_____
_____ Medical Records_____
_____ Laboratory/Radiology_____
_____ Phone contact regarding (specify content to be released)_____
_____
_____ Other (please specify)_____
_____ To _____ From_____ the following health care provider/facility:
_____
Individual Releasing/Obtaining Information Title
_____
Name of facility/Organization Address
_____
City State Zip Phone

For the purpose of

_____Continuing Patient Care _____Evaluation and Referral
_____Disability Determination _____Legal Proceeding
_____Insurance Claim _____Other_____

I understand that I may revoke this authorization at any time except to the extend that action has already been taken in reliance hereon. If not revoked sooner in wirting, this content will expire one year from the date below or on _____ at my election. I understar I that I have the right to examine and copy the information to be disclosed, unless deemed that such disclosure is not in my best interest.

This information has been disclosed to you from records whose confidentiality is prohited from making any further disclosure of these records. A general authorization for rlease ofm edical or other information isn ot sufficient for this purpose. This information is protected by both State (Section 34-2A-18 NMSA 1953) and Federal (42-CFR Part 2) regulations.

_____ _____ _____
Name (please print) Date of Birth Social Security Number

_____ _____ _____
Patient Signature Guardian/Legal Rep. Date Signed

Witness Signature_____ Date signed_____

Date Mailed/Processed_____ by (Staff initials)_____