



Authorization to Release Protected Health Information (PHI)

THIS FORM GRANTS PERMISSION TO NEW MEXICO HEALTH CONNECTIONS TO RELEASE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME TO THE PERSONS OR ENTITIES SPECIFIED ON THIS FORM.

VERIFICATION OF MEMBER – This is the person for whom information is to be released.

Form with fields for Member Name, Date of Birth, Member ID, and Is member a minor?

VERIFICATION OF SUBSCRIBER – This is the policyholder, and may be different from the Member.

INFORMATION REQUESTED – I authorize NMHC to release the following information (check all that apply):

- Checkboxes for Claims information, Medical treatment, Payment information, Enrollment information, etc.

RELEASE MY PHI TO (Name of Authorized Recipient): _____

HOW DO YOU WANT THE INFORMATION SENT?

- Checkboxes for Mail (address), Fax to, Email to, Shared by telephone

This authorization will expire on: _____

The purpose for this release is: _____

AUTHORIZATION

- I understand that if the information on this form is not complete... I understand that I may end or change this Authorization... Customer Care for assistance.

I have read and understand the above information and duly authorize the persons or entities named to receive my PHI.

Member Signature

Date

If you are making this request on behalf of a minor child, NMHC may require additional information before this request will be considered complete.

If you are an appointed representative making this request on behalf of an adult member who is unable to give consent, NMHC will require verification of the authority of Personal or Legal representation before this request will be considered complete.

Signature of Representative Date

Signature of Representative Date

FAX COMPLETED FORM TO: NEW MEXICO HEALTH CONNECTIONS, 1-866-628-3047, OR MAIL COMPLETED FORM TO: NEW MEXICO HEALTH CONNECTIONS, P.O. BOX 36719, ALBUQUERQUE, NM 87176