

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 inform	ation is to be released.	
Full Name of Member:	Date of Birth:	
Member ID or Social Security Number:	Is member a minor? Yes No	
VERIFICATION OF SUBSCRIBER – This is the policyholder, and mar	y be different from the Member.	
INFORMATION REQUESTED − I authorize NMHC to release the fo ☐ Claims information ☐ Medical treatment/diagnostic Information, including genetic testing, HIV/AIDS, pregnancy, drug/alcohol abuse, and mental/behavioral health	 □ Payment information □ Enrollment information □ Verification of medical referrals and/or prior □ All/any of the reasons listed 	authorization
RELEASE MY PHI TO (Name of Authorized Recipient):		
HOW DO YOU WANT THE INFORMATION SENT? Mail (address):		
Fax to:		
Email to:		
Shared by telephone (list phone number):		
This authorization will expire on:		
The purpose for this release is:		
 I understand that if the information on this form is not complete, the form will be returned to me and the requested Protected Health Information will not be released until NMCH has received a complete form. I understand that I may end or change this Authorization at any time by sending written notice to NMHC or by completing a new Authorization for Release of Protected Health Information (PHI). Any revocation of this Authorization will not be effective for any actions NMHC has already taken. Please contact 	 Customer Care for assistance. I understand that after PHI is disclosed to recipient(s) specified in this Authorization might not protect the disclosed informat information might be redisclosed withou knowledge or approval. I understand that NMHC may not conditi payment, enrollment or eligibility for ber whether I sign this authorization. 	n, federal law ion and that t my on treatment,
I have read and understand the above information and duly author	rize 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. By signing this form, you represent and warrant that you are the Member's Personal and/or Legal Representative.	If you are an appointed representative making this behalf of an adult member who is unable to give of will require verification of the authority of Person representation before this request will be consider	consent, NMH(al or Legal
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