new mexico health connections

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.

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 may be different from the Member.

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

- ☐ 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 authorization
- ☐ All/any of the reasons listed

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): _____

The purpose for this release is: _____

This authorization will expire two years after the signature date.

AUTHORIZATION

- 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 the recipient(s) specified in this Authorization, federal law might not protect the disclosed information and that information might be redisclosed without my knowledge or approval.
- I understand that NMHC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

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. 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 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