NEW MEXICO MEDICAL REVIEW COMMISSION
AUTHORIZATION TO DISCLOSE OR USE PROTECTED MENTAL HEALTH CARE INFORMATION
(Separate Authorization Required for Each Provider)

_____ _____/_____/_____ _____-____-_____
Patient's Full Name Date of Birth Social Security No.

The undersigned is the patient or the legally authorized patient's representative.
I authorize _____ (provider name)
to disclose written mental health information from _____(date) to_____ (date),

(Initial *ONLY* those records to be released):

_____ Psychotherapy notes

_____ Health records related to Emotional Health, Behavioral Health, Mental Health, Developmental Disabilities, Psychiatric Conditions (**Excludes psychotherapy notes)**

The above health records are released to New Mexico Medical Review Commission° which, pursuant to the New Mexico Medical Malpractice Act, NMSA 1978, ' 41-5-1ff. consists of: (a) the administrative staff, (b) the director and/or its designee, (c) counsel for the parties and a certified court reporter, and (d) the commissioners (i.e. three lawyers and three health care providers):

New Mexico Medical Review Commission
316 Osuna NE #501
Albuquerque, NM 87107
Telephone (505) 828-0237
Facsimile (505) 828-0336

The information that I disclose will be used for the following purposes: Hearing before the New Mexico Medical Review Commission Medical Legal Panel and other related issues

EXPIRATION: I understand that I may cancel this authorization at any time by sending the New Mexico Medical Review Commission written notice unless the Commission has already taken action in reliance on the authorization. Unless cancelled, this Authorization expires thirty (30) days after the decision of the Medical Review Commission is rendered. If the Medical Review Commission does not render a decision on this matter, this Authorization will expire six months from the date it was signed by the patient or personal representative.

The cost of duplicating shall be at the sole expense of the New Mexico Medical Review Commission. A photocopy or facsimile of this authorization shall be as valid as an original.

I understand that this authorization is voluntary and I may refuse to sign it. I need not sign this form in order to assure treatment. Pursuant to CFR 164.524, I may inspect or copy the information provided. I have the right to receive a notice of privacy from any health care provider that discloses the above protected health information.

Signature of Patient or Authorized Representative: _____
Name and Capacity Printed: _____
Date of Signature: _____, 200___

° ***Prohibition of Re-Disclosure.*** *Federal Law (e.g.45 CFR160ff.) and State Law (NMSA 1978, §24-1-9.5(1996), §24-2A-6(1997), and §32A-6-15 (1995)) prohibit further disclosure of HIV/AIDS, other sexually transmitted diseases, mental health, alcohol/drug abuse information.*