HOMEGROWN, LLLP
4200 SILVER AVE SE SUITE A | ALBUQUERQUE, NM 87108
PHONE: (505) 508-2417 | FAX: (505) 492-2164

# Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

**I, _____**
**(printed name)**

**authorize**
Homegrown, LLLP, a covered entity, to release my complete medical record to

**➞Name: _____**

**➞Address: _____**

**➞City: _____ ➞State: _____ ➞Zip code: _____**

**➞Telephone number: (_____) _____-_____**

**➞Fax number: (_____) _____-_____**

**The dates for the release of my complete medical records are:**

**_____/_____/_____ thru _____/_____/_____**

**OR**

**☐Release all records available**

**Reason for record request:**

_____

**My patient information is as follows:**

**➞Name: _____ ➞Date of birth: ___/___/_____**

**➞SSN (Last 4 digits only): _____**

**➞Address: _____**

**➞City: _____ ➞State: _____ ➞Zip code: _____**

**➞Telephone number: (_____) _____-_____**

**By signing this form,**

➞I understand that authorizing the disclosure of this patient health information is voluntary.
➞I understand that this authorization will expire six months after being signed.
➞I understand that this authorization may be canceled at any time in writing, but will not change releases already in progress.
➞I understand that once the above information is disclosed, that it carries with it the potential for further release or distribution that may not be protected by confidentiality laws despite conscious effort.
➞I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.
➞I understand that I am specifically authorizing the release of any sensitive medical information in my medical records for mental health treatment, sexually transmitted diseases, AIDS/HIV treatment, or alcohol/drug treatment unless I specify below:

☐I do not authorize the release of sensitive information regarding mental health treatment, sexually transmitted diseases, HIV/AIDS treatment, or alcohol/drug treatment.

**➞Patient/Legal Guardian Signature: _____**

**➞Date: _____**