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

All medical sources (any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, or other healthcare provider that has provided payment, treatment, or services to me or on my behalf*) to disclose:

- **Clinic or Progress notes**
- **History**
- **Laboratory Results**
- **XRAY and imaging results**

between the dates specified below to Homegrown, LLLP, a covered entity, at my request for the **purpose of continuing treatment**.

*Pursuant of 45 CFR 164.508(c)(1)(iii) or refer to https://www.hhs.gov/hipaa/for-professionals/faq/473/may-a-valid-authorization-list-categories-of-persons-who-may-use-protected-information/index.html for listing categories of those authorized to release health information

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

_____/_____/_____ thru _____/_____/_____

OR

Most recent 12 months if these dates specified are not valid

In the form of:

- **A hard copy:** Faxed to Homegrown, LLLP at (505) 492-2164 OR

  Mailed to Homegrown, LLLP | 4200 Silver Ave SE Suite A | Albuquerque, NM 87108

- **Electronic copy or access via a web-based portal**

To ATTN: Marissa Ramirez, Case Manager OR Homegrown, LLLP

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 entitled to inspect or copy the patient health information that I am authorizing to be used or disclosed.
➞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: _____

Please list your providers. At least one must have been seen within the last 12 months. Out of state providers are permitted.

Hospital or office name: _____

City or town: _____

Phone number: (____)_____-_____

Hospital or office name: _____

City or town: _____

Phone number: (____)_____-_____

Hospital or office name: _____

City or town: _____

Phone number: (____)_____-_____

Hospital or office name: _____

City or town: _____

Phone number: (____)_____-_____

Hospital or office name: _____

City or town: _____

Phone number: (____)_____-_____