

**New Mexico Tech Counseling Center Authorization for Release of Health/Mental Health Information**

**Status: ( ) Current NMT Student ( ) Previous NMT Student:**

**Year Graduated:\_\_\_\_\_\_\_\_\_\_\_ Last Year Seen by Counseling Center: \_\_\_\_\_\_\_\_\_\_\_**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Banner ID# (900 #)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dates of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize The New Mexico Tech Counseling Center, located at 149 Fidel Building, 801 Leroy Place, Socorro, NM 87801 (phone 575-835-6619) to:

**( ) disclose information to ( ) receive information from**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The information disclosed is for:**

( ) dates of counseling contacts

( ) summary of counseling treatment

( ) Intake Form

( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The purpose of this disclosure is for:**

( ) treatment planning

( ) legal

( ) Insurance

( ) Personal

( ) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* This authorization expires 90 days from the date it is signed or upon completion of.
* Records are kept seven (7) years from last Counseling Center contact with client.
* I understand that treatment may not be conditioned on signing an authorization. ⁭
* I understand that I may revoke this authorization in writing and that the revocation will be honored **unless good faith action has already been taken in reliance on this authorization** ⁭
* I understand that information released may be re-released by the recipient and may, therefore, no longer be covered by the Privacy Rule. ⁭
* I understand that I have a right to receive a copy of this authorization.
* I understand that if records are for personal use, some documents may be redacted.
* Insurance applicants: withholding or release of information may be governed by your insurance company’s regulations, state law, and/or federal law.

**SIGN HERE:** **X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient/legal representative signature) (Today’s Date)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Indicate representative’s authority to act on

patient’s behalf (e.g., legal guardian)

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 (Witness) (Today’s Date)