

**NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION  
WORKER'S AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH RECORDS**

Worker/Patient FULL NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: XXX-XX-\_\_\_\_\_

FOR WCA REFERENCE ONLY: Date/s of Injury: \_\_\_\_\_ WCA Case File Number: \_\_\_\_\_

**INSTRUCTIONS FOR USE:** In accordance with NMSA 1978, § 52-10-1, a workers' compensation health care provider shall not require a signed medical authorization, in any form, for records that are directly related to any work place injuries or disabilities claimed by an injured worker. Costs for copying records are subject to non-clinical services fees set by the Administration, and shall not exceed \$1.00 per page for the first ten (10) pages or up to twenty-cents (\$0.20) for each page thereafter. A copy of this authorization may be used as an original.

**RELEASE OF HEALTH CARE RECORDS**

I, (Print Worker's Name) \_\_\_\_\_, hereby authorize the following health care provider (HCP) or named facility to release my health care records for the **PURPOSE OF** facilitating and evaluating my Worker's Compensation Claim that arises from alleged workplace injuries or illnesses that occurred on the above date/s of injury.

Provider or Facility: _____	
Address: _____	
_____	
_____	

I authorize the following records released (check box, as appropriate):  **ALL RECORDS** /  **SPECIFIC DATES** (provide a date range for records authorized to be released ( \_\_\_\_\_ ))

**RELEASE OF SPECIFIC HEALTH RECORDS**

I FURTHER AUTHORIZE THE RELEASE OF RECORDS THAT MAY CONTAIN INFORMATION ABOUT THE FOLLOWING: (initial any that may apply).

Treatment for alcohol and/or substance abuse     
  Sexually transmitted diseases     
  HIV or AIDS  
 Behavioral or Mental Health, including Psychiatric or Psychological  
 Records of the Department of Health Medical Cannabis Program

\_\_\_\_\_  
Signature of Worker/Patient/Personal Representative \_\_\_\_\_  
Date

**PERSON/ENTITY AUTHORIZED TO RECEIVE RECORDS**

I authorize records be released to my employer, my employer's insurer, my attorney or representative, my employer/insurer's attorney or representative, and IME providers.

(To be completed by authorized recipient/s): Records to be  Picked Up  Mailed  Emailed  Faxed  Other (specify) \_\_\_\_\_

Authorized Recipient/s: _____	
Address: _____	
_____	
Fax/Email: _____	

<b>EXPIRATION and CONDITIONS</b>	I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN IT AND SUCH A REFUSAL TO SIGN MAY NOT AFFECT MY TREATMENT OR SERVICES, EXCEPT AS PERMITTED BY LAW. THIS AUTHORIZATION IS LIMITED TO USE AND DISCLOSURE OF MEDICAL RECORDS AND DOES NOT WAIVE ANY PATIENT DOCTOR PRIVILEGE WITHOUT MY SEPARATE AUTHORIZATION AND CONSENT. THIS AUTHORIZATION IS TO BE VALID FOR TWO (2) YEARS FROM THE DATE OF MY SIGNATURE. I UNDERSTAND INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE RECIPIENT/S. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE HEALTH CARE PROVIDER OR FACILITY IN WRITING; A COPY OF ANY REVOCATION SHOULD BE PROVIDED TO THE RECIPIENT/S. UPON MY REQUEST, I AM ENTITLED TO A COPY OF THE SIGNED AUTHORIZATION.
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\_\_\_\_\_  
Signature of Worker/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Personal Representative (if any)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Personal Representative

\_\_\_\_\_  
Relationship to Worker/Patient