NEW MEXICO
LAW OFFICES OF THE
PUBLIC DEFENDER

Chief Public Defender
Bennett J. Baur

Request for Release of Information

To: _____ **Date:** _____

Re: Last name: _____ **First name:** _____ **MI:** _____

DOB: _____ **SSN:** _____

I, _____, authorize you to release my personal health information including, but not limited to, medical, psychological, psychiatric, alcohol and drug treatment records to my attorney, or any representative, of the Law Offices of the Public Defender. I also authorize you as doctors, experts or personnel of your facilities to discuss my otherwise confidential information with my attorney or their representatives. You may photocopy records and release copies to my attorneys or their representatives at the New Mexico Law Offices of the Public Defender (NM LOPD),

For the purpose of: _____

In addition, I acknowledge that these records may include or contain reference to the following subjects, and I authorize the following materials to also be released if requested:

- Any and all medical records and documents which relate to the diagnosis and treatment of drug/alcohol substance abuse.
- Any and all medical records, reports and documents which relate to the diagnosis and treatment of any emotional or mental health/psychiatric condition.
- Any and all medical records, reports and documents which relate to the diagnosis and treatment of Human Immune Deficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS).

Covering the period/date of healthcare/treatment from: _____ **to:** _____

I understand that I have a right to revoke this Authorization at any time. I acknowledge that if I do revoke this Authorization, I must do so in writing and present my written revocation to a representative of LOPD. I understand that I cannot revoke information that has already been released under this Authorization.

Unless revoked, this Authorization will expire on the following date: _____. If not specified, this Authorization will expire one year from the date it was signed.

I acknowledge that I am authorizing the disclosure of this information voluntarily and can refuse to sign this Authorization if I choose to. I have a right to examine and copy any information that is disclosed. A copy of this signed Authorization will be provided to me.

PROHIBITION OF REDISCLOSURE: Federal regulations (42 CFR Part 2 and 45 CFR 164.502(a)(5)(iii)) and State Laws (NMSA 197843-1-19, 32A-6A-24-2B-7 and 24-1-9.4) prohibit further disclosure of mental health or alcohol and/or drug abuse treatment information, reproductive health information and of the results of tests for HIV/AIDS and other sexually transmitted diseases to any person or agency without securing another proper written authorization for that purpose, or as otherwise permitted by federal regulations or state laws.

ATTESTATION: I attest that the use or disclosure of PHI that I am requesting is not to investigate or impose liability on any person for seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes as prohibited by 45 CFR 164.502(a)(5)(iii).

SIGNED: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____