Sage Neuroscience Center

7850 Jefferson St. NE Suite 300 Albuquerque NM, 87109

This authorization allows Sage Neuroscience to disclose confidential health information about you. The Authorization may be revoked. It will remain in effect for one year unless a different time is stated. You are entitled to a copy of the completed authorization.

CLIENT

Client Name (First, Middle, Last) (Please Print):	Date of Birth (mm/dd/yyyy):
Client Address (Street or P.O. Box, City, State, Zip Code):	
Phone Number:	

This authorization party has permission to: (ONE PER FORM)

☐ **Permission to speak with for scheduling** **OR** ☐ **Permission to speak with regarding care and scheduling**

Authorized Individuals Name (First, Last):	Relationship to Client:
Authorized Individuals Address (Street or P.O. Box, City, State, Zip Code)	
Phone Number:	Fax Number:

RECORDS-REQUEST

MEDICAL RECORDS REQUEST ONLY:

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1. I authorize the use or disclosure of the health information as described below.
2. I understand that any information disclosed may include information relating to Sexually Transmitted Diseases (STD), acquired immunodeficiency syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, and information obtained by Sage Neuroscience Center or other providers. **By initialing here I agree to the release of BH records, Drug & ETOH Treatment, and STD Treatment:** ____________

The type and amount of information to be disclosed is as follows: *(fill out all that apply, dates are required)*

a. ☐ **All Records*** *Excludes Psychotherapy* From (date) ______/____/______ To (date) ____/_____/______ or ☐ Most Recent Only
b. ☐ Initial Evaluation From (date) ______/____/______ To (date) ____/_____/______ or ☐ Most Recent Only
c. ☐ Follow-Up Visit Notes From (date) ______/____/______ To (date) ____/_____/______ or ☐ Most Recent Only
d. ☐ Discharge Summary From (date) ______/____/______ To (date) ____/_____/______ or ☐ Most Recent Only
e. ☐ Psychotherapy Notes From (date) ______/____/______ To (date) ____/_____/______ or ☐ Most Recent Only
f. ☐ Drug and Alcohol Treatment From (date) ______/____/______ To (date) ____/_____/______ or ☐ Most Recent Only
g. ☐ Other: (must be specific) ____

This health information shall be disclosed to and used by the following individual or organization: (ONE PER FORM)

☐REQUEST RECORDS BE SENT TO **or** ☐ REQUEST FOR RECORDS BE OBTAINED FROM

Name of Individual or Organization:	Phone:
Individual or Organization (No. and Street Address, City, State, Zip):	Fax:

This authorization will expire in one year unless another expiration date is specified here: _____/____/_____ (mm/dd/yyyy)

STATEMENT OF UNDERSTANDING: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the Medical Records office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment from Sage Neuroscience Center. I understand that I may inspect or receive copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the redisclosure may not be protected by federal confidentiality rules. I have a right to limit the information disclosed. A faxed copy of this release is acceptable for releasing PHI.

To revoke this authorization or if you have a question about disclosure of your health information, contact the Medical Records Department.

SIGNATURE

Signature of Client or Personal Representative:	Date:
If Signed by Personal Representative, Relationship to Client:	Date:
Signature of Witness (Sage Neuroscience Staff Member):	Date: