THE UNIVERSITY OF NEW MEXICO

Student Health & Counseling (SHAC)
MSC06 3870
1 University of New Mexico
Albuquerque NM 87131-0001
(505) 277-3136 Fax: (505) 277-2020

Authorization for Release of Information

Please fill out this form completely; incomplete forms are invalid and will not be processed.

Patient's Name: _____Birthdate: _____Phone #: _____
Maiden/Alternate Name (if applicable): _____
UNM ID, Medical Record#, or Last 4 Digits of SSN#: _____

This will authorize: UNM Student Health and Counseling (SHAC) to: ◯ SEND: or ◯ RECEIVE:
the information requested below: ◯ TO: or ◯ FROM:

Name:	
Address:	
City/State/Zip:	
Telephone #	
Fax #	

Check √	Information Requested:	Specify dates/conditions/diagnoses etc.
☐	**Billing Information:**	
☐	**Immunization Records:**	
☐	**Laboratory Reports:**	
☐	**Radiology Reports:**	
☐	**Visit Notes:**	
☐	**All Medical Information:**	
☐	**Other:**	

Check √	SHAC Counseling Records or Other Behavioral, Counseling or Psychotherapy Records:	Specify dates/conditions/diagnoses etc.
☐	**Psychiatry Records**	

I understand the information requested may include information related to the following, and I specifically authorize the release of such information as indicated by my initials otherwise the information will not be included.

Drug/Alcohol Abuse:		***HIV/AIDS:***	
Sexually Transmitted Diseases/Infections:		***Behavioral or Mental health***	

For the purpose of: _____ (required).

Preferred Method: ☐ Via mail

AUTHORIZATION: I certify that this request was made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by notifying UNM Student Health & Counseling in writing. I understand any request for revocation will not have any effect on any actions taken prior to submission of the request. I understand that if the entity authorized to receive the information is not a health plan or healthcare provider the released information may not be protected by federal privacy regulations. I understand that this authorization in voluntary and that I may refuse to sign it and that signing it is not a condition of treatment or payment for services. This authorization will expire 180 days from the date of signature unless otherwise stated. I understand that this request may result in an administrative copying fee.

_____ _____
Signature of Patient/Client (or Legal Representative) Date

_____
If Legal Representative, Relationship to Patient