First Choice
COMMUNITY HEALTHCARE

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient's Full Name: _____ Date of Birth:_____

I authorize _____ to release (disclose) the following health
(Name and complete address of facility)
records of the above named patient to:

☐ FCCH South Valley, 2001 N. Centro Familiar, SW Albuquerque, NM 87105; Fax # (505) 877-4400
☐ FCCH South Broadway, 1316 Broadway, SE Albuquerque, NM 87102; Fax # (505) 842-1185
☐ FCCH North Valley, 1231 Candelaria Road, NW Albuquerque, NM 87107; Fax # (505) 344-4056
☐ FCCH Alamosa, 6900 Gonzales Road, SW Albuquerque, NM 87121; Fax # (505) 831-4123
☐ FCCH Alameda, 7704-A 2nd Street, NW Albuquerque, NM 87107; Fax # (505) 890-1599
☐ FCCH Edgewood, 8 Medical Ctr. Rd. / P.O. Box 2606 Edgewood, NM 87015; Fax # (505) 224-8737
☐ FCCH Los Lunas, 1259 Highway 314 Los Lunas, NM 87031; Fax # (505) 224-8727
☐ FCCH Belen, 120 South Ninth Street Belen, NM 87002; Fax # (505) 224-8717
☐ _____
(Complete Name and Address of facility sending to)

Covering the period(s) of healthcare: from (date) _____ to (date) _____

Information to be disclosed including:

☐ Progress notes ☐ Laboratory tests ☐ Discharge summary
☐ X-Ray reports ☐ Outside records from other providers
☐ Other _____

In addition to release of the general health records indicated above, by initialing below I also authorize the release of health records pertaining to the following conditions.
(Initials must be obtained for ONLY those records to be released):

_____ Psychotherapy Notes **(If initialed, the authorization may NOT authorize the release of any health records other than Psychotherapy Notes) in order to release other health records, a separate authorization is required**
_____ Health Records Related to Emotional, Mental Health, Developmental Disabilities, Psychiatric Conditions **(Excludes Psychotherapy Notes)**
_____ Health Records Related to Drug/Alcohol/Substance Abuse
_____ Health Records Related to Sexually Transmitted Diseases
_____ Health Records Related to Human Immune Deficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)

Expiration: I understand that I may cancel this authorization at any time by sending my notice of cancellation in writing. I understand that FCCH may have already used or released records according to this authorization prior to receiving my notice of cancellation. I understand that if this authorization is cancelled, an insurer may still have the legal right to contest a claim or the insurance policy. This right only applies if this authorization is requested as a condition of obtaining insurance coverage. **Unless cancelled, this authorization expires (either event or date is required):**

☐ In one year _____ ☐ When other event occurs (specify) _____
(Date)

I understand that this authorization to release health records is voluntary and that I may refuse to sign this authorization. Signing this authorization is not a condition of patient receiving treatment or payment for services, except as permitted by law. I have read and understand the above information:

Signature of Patient or Parent/Guardian: _____ Date: _____

Relationship if person signing is other than patient: _____ Date: _____

FCCH Label

F. 180 Rev. 10/08