New Mexico Public Schools Insurance Authority

Authorization For Release of Health Information

Policy Holder Name:	
Patient Name:	

I, _____ *(Patient Name)* hereby authorize New Mexico Public Schools Insurance Authority the use or disclosure of my health information as described in this authorization.

A. Specific person/organization authorized to provide the information:

Please select all that this release applies to:

☐ Blue Cross Blue Shield	☐ Presbyterian	☐ CVS	☐ Davis Vision	☐ BCBS Dental	☐ Delta Dental
☐ United Concordia					

Name of Provider:		☐ Out of Network	☐ In Network
Provider Phone Number:			
Provider Email:			

B. Information regarding your claim (Please provide detailed information of what your issue is. Include date of service and names of RX or procedures you would like reviewed.) Attach all supporting documents.

C. Please state the purpose of your request (for example "assistance with claim", "RX cost reduction" etc.) and what you would like to see as the outcome.

D. Right to revoke. I understand that I have the right to revoke this authorization at any time by notifying NMPSIA in writing at 410 Old Taos Highway, Santa Fe, NM 87501. I understand that the revocation is only effective after it is received and logged by NMPSIA. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

E. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my inquiry or appeal has been acted upon by NMPSIA.

F. Personal representative section: If a Personal representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of:

Representative Name:	
Representative Phone/ Email:	

Signature of Patient (if over 18) **Date:**

Signature of Policy Holder (if patient is under 18) **Date:**

Signature of Personal Representative **Date:**