New Mexico Public Schools Insurance Authority

MEMBER AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ (Member Name) hereby authorize the use or disclosure of my health information as described in this authorization.

A. Specific person/organization (or class of persons) authorized to **provide** the information:

_____ (name of health plan)

_____ (name of providers as applicable)

_____

B. Specific person/organization (or class of persons) authorized to **receive and use** the information:

New Mexico Public Schools Insurance Authority
410 Old Taos Highway, Santa Fe, NM
800-548-3724
Fax: 505-983-8670

C. Specific and meaningful description of the information (for example, "relating to xxxxxxx treatment with date of service xxxxxxx rendered or proposed by xxxxxxxxx" (provider) attach all supporting

D. Purpose of the request. (Please state the purpose of the request below, for example "assistance with claim". If you do not wish to state a purpose, please state "at the request of the individual")

E. 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.

F. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.

G. I understand that I am entitled to receive a copy of this authorization.

H. I understand that this authorization will expire when my inquiry or appeal has been acted upon by NMPSIA.

Signature of Employee or Patient (if over age 18) _____ Date: _____

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: