iNetMed Rx² Inc.

Patient Name DOB: Patient Status: Minor Adult

Parent/Guardian Name:

Patient/Parent/Guardian Address:

Patient/Parent/Guardian Phone: Fax: Email:

Information To Be: **Released** ☐ **Received** ☐

Name /Agency iNetMed Rx² Inc

Address 1635 S. Don Roser Drive

Phone Las Cruces, NM 88011

Fax 575.636.2506

575.288.2691

Information To Be **Released** ☐ **Received** ☐

Name /Agency _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Fax _____

Purpose of Release

Coordination of Care ☐ Written Disclosure ☐ Verbal Disclosure ☐

Secure Email Disclosure ☐ Secure Email Disclosure ☐

INFORMATION TO BE RELEASED:

Psychiatric/Psychological Progress Notes ☐

Diagnosis, Medication Plan, Treatment Plans, Goals ☐

Diagnosis ☐

Medication ☐

Treatment Plan/ Goal ☐

Imaging Studies ☐ Lab Studies ☐ Evaluations ☐

Other (Specify): _____

INFORMATION FOR INFORMED CONSENT

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including New Mexico Revised Statutes and Title 42 of the Code of Federal Regulations. These Statutes, Rules and Regulations require that the individual give informed consent prior to the release of any health records or information, except as specifically provided for within the Statutes, Rules and Regulations. A consent to release information will be considered valid only when it states: (1) who will A consent to release information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose for which the information will be used; (4) what specific information will be released; and (5) when the consent will expire. The consent must contain the individual's or authorized representative's signature and the date of the signature. The authorized representative signing for the client must submit a copy of the legal document (s) granting this authority. This authorization for the Release of Health Protected Information waives any and all rights that the individual now has to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. Upon request, the individual will be given a copy of the completed "Authorization for the Release of Client Information."

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization expires 365 days from the date of signing or upon case closure, whichever occurs first.

Patient / Parent Signature: _____ Date _____/_____/20

Staff Signature: _____ Date _____/_____/ 20