



HopeWorks and Bernalillo County Release of Information (ROI)

Attn: _____

Authorization to Request/Release Information

Requesting Agencies

HopeWorks
 Attn: Abby Long
 PO Box 27258
 Albuquerque, NM 87125

Bernalillo County Housing Community Connections
 2400 Wellesley NE Ste. 100
 Albuquerque, NM 87107
 Main # 314-0200

This authorizes Hopeworks and Bernalillo County Community Connections to request and/or release the following information from/to (name and address of person/agency):

Regarding Client: _____

Date of Birth: _____ SS#: _____

The information to be disclosed is:

- | | |
|--|---|
| <input type="checkbox"/> Psychosocial History | <input type="checkbox"/> Psychological Evaluation |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History and Physical Examination |
| <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Psychiatric History |
| <input type="checkbox"/> Educational Information | <input type="checkbox"/> Medication History |
| <input type="checkbox"/> Laboratory Data | <input type="checkbox"/> Aftercare Plan |
| <input type="checkbox"/> Verbal and Written Progress Reports | <input type="checkbox"/> Other: _____ |

This information is needed for the following purpose(s): _____

I understand that the information to be released may include information regarding the following condition(s):

Initial Chemical abuse and/or dependency AIDS-HIV testing

I understand that I have the right to examine and copy the information to be released. I also understand this authorization expires automatically in one (1) year from date on signature or on _____ and that, although I may withdraw this authorization at any time earlier, some information may already have been released. I have been told that information released from my records may not be given to people or agencies other than those named on this form without my permission (Section 34-2A-18 NMSA 1953).

 (Signature of Client)

 (Signature of Witness)

 (Date)

 (Signature of Representative)

If client is unable to sign, state reason: _____

This information is requested from records whose confidentiality is protected. The receiving agency is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for the request of medical or other information is not sufficient for this purpose. This information is protected both by the State (Section 34-2A-18 NMSA 1953) and Federal (42 CFR Part 2) Regulations.