New Mexico Medical Insurance Pool
"When no one else will help, we're there"

Authorization for Release of Protected Health Information

Uses and disclosures of your protected health information not otherwise described in the Notice of Privacy Practices or the laws that apply to the New Mexico Medical Insurance Pool (the "Plan(s)") will be made only with your written permission. If you want the Plans to disclose your protected health information in a manner or to a person not otherwise described in the Notice of Privacy Practices or the laws that apply to the Plans, please provide the information requested below, sign this Request and submit it to Member Services Monday through Friday during the hours of 8:00 a.m. and 5:00 p.m. CST at nmmip_eligibility@90degreebenefits.com In the alternative, you may submit this Authorization by depositing it in the United States mail, postage prepaid, and addressed to Enrollment Services, New Mexico Medical Insurance Pool, PO Box 780548, San Antonio, Tx 78278 or submitted by fax to Member Services (210) 239-8449.

Individual Information. Please provide the following information:
Name: _____; Date of Birth: ____/____/____;
Member ID No./ Social Security Number:_____; Telephone Number:_____;
Address: _____.

Identification of Information to Which This Authorization Applies. I hereby request the Plan(s) to release and disclose the protected health information specified below (please check one or more):

☐ Full record. ☐ Full record for the period ____/____/____ to ____/____/____.
☐ Enrollment information. ☐ Premium / contribution payment information.
☐ Claims and billing information relating to the following service or claim (specify date of service and/or medical condition): _____
_____

☐Other (please specify):_____
_____

Identification of Persons / Organization to Which This Authorization Applies. I hereby request that the following persons or organizations be allowed to use and/or receive the protected health information specified above: _____.

Expiration Date of Authorization. This Authorization shall remain in effect until 12 months after termination of benefits under the health plan unless you specify a different time period or revoke the authorization. _____
_____.

Your Rights. By signing and submitting this Authorization, you acknowledge the following statements about your rights: (1) This Authorization is voluntary and you are not required to sign it; (2) You are not required to sign this Authorization to receive health care benefits under the Plans; (3) You may revoke this Authorization at any time prior to its expiration date by notifying the Plans in writing, however, the revocation will have no effect on any actions the Plans may have taken prior to receipt of your revocation; (4) You have the right to inspect and copy the protected health information covered by this Authorization; (5) The information that is to be used or disclosed pursuant to this Authorization may be disclosed by the person(s) or organization(s) authorized by you to receive the information; and (6) You may revoke this Authorization at any time. Your revocation of this Authorization must be in writing and must be signed by you.

_____ _____
Signature Date

_____
Print Name

Please Note: ***This request must be accompanied by a picture ID (e.g. valid driver's license, passport or other photo ID issued by a government agency).*** *If this form is signed and submitted by a person other than the individual identified above, the Plan will require verification of the authority of the person signing on behalf of the individual before this request will be considered complete.*