NEW MEXICO STATE BOARD OF PSYCHOLOGIST EXAMINERS

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH RECORD INFORMATION

(Includes inspection/copying of mental health records)

COMPLAINT NO: ___________

NAME OF PATIENT (LAST) (FIRST) (M.)

BIRTHDATE TELEPHONE

ADDRESS

THE UNDERSIGNED HEREBY AUTHORIZES AND REQUESTS THAT:

___________________________________ ___________________________________

(Name of Health Care Provider) Address

RETURN TO:
BCD.Compliance@state.nm.us

Access to my mental health records for the purposes of review and examination, and further authorizes and requests that you provide such copies thereof as may be requested.

___________________________________ ____________________

PATIENT (OR GUARDIAN) SIGNATURE Date