



New Mexico Department of Health
Medical Cannabis Program – Consent for Release of Medical Information

I, _____, as an applicant for enrollment in the New Mexico Department of Health (NMDOH), Medical Cannabis Program (MCP), consent to allow the MCP Medical Director and/or the MCP Coordinator, to review my medical records. I understand the purpose of this review is to verify my debilitating medical condition as required for enrollment in the MCP and mandated by the Lynn & Erin Compassionate Use Act of 2007.

I also understand any information obtained may include information relating to Sexually Transmitted Diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse and information obtained by the New Mexico Department of Health from other providers.

This authorization applies to health information to be obtained by the New Mexico Department of Health Medical Cannabis Program.

The type and amount of information to be obtained is as follows (include dates where appropriate):

- a. ___ Treatment Plan from (date) ___/___/___ to (date) ___/___/___ or Most Recent Only ___
b. ___ Immunization record from (date) ___/___/___ to (date) ___/___/___ or Most Recent Only ___
c. ___ History from (date) ___/___/___ to (date) ___/___/___ or Most Recent Only ___
d. ___ Physical from (date) ___/___/___ to (date) ___/___/___ or Most Recent Only ___
e. ___ Discharge Summary from (date) ___/___/___ to (date) ___/___/___ or Most Recent Only ___
f. ___ Laboratory Results from (date) ___/___/___ to (date) ___/___/___ or Most Recent Only ___
g. ___ X-ray and Imaging Reports from (date) ___/___/___ to (date) ___/___/___ or Most Recent Only ___
h. ___ Consultation Reports: from (doctors' names) _____
i. Other: _____
j. Special instructions or limitations: _____

Statement of Understanding

I can refuse to sign this authorization and I have a right to revoke it at any time. I understand if I revoke this authorization, I must do so in writing to the Medical Cannabis Program Coordinator, and revocation may result in the inability for the program to certify me as a Medical Cannabis Program participant. I understand the revocation will not apply to information already reviewed in response to this authorization. I understand that unless I revoke this authorization as stated above, this authorization will expire in one (1) year unless I have specified a different date of expiration. I understand that authorizing the review of this health information is voluntary and I can refuse to sign this authorization. By signing this form I consent to the release of my medical records and discharge the New Mexico Department of Health from all liability regarding the disclosure of this information. I understand I have a right to limit the information obtained and I have the right to inspect or receive copies of the information to be obtained, as provided in 45 CFR 164.524.

Unless revoked, this consent for release of medical information will expire one (1) year from the signed date.

Signatures:

Participant or Personal Representative: _____ Date: _____
If Signed by Personal Representative, Relationship to Participant: _____
Signature of Witness: _____ Date: _____