Medical Authorization Instructions

THE PROVIDED INFORMATION IS FOR INFORMATIONAL PURPOSES ONLY AND DOES NOT CONSTITUTE APPROVAL OF SERVICE, ACCEPTANCE OF LIABILITY OR LEGAL ADVICE.

What is the WCA Medical Authorization?

This is a form you will complete to provide written authorization for New Mexico Mutual (the insurance company) to collect medical records related to your worker's compensation injury.

Why do I need to fill this out?

So that the insurance company can collect pertinent medical information related to your claim for Workers' Compensation benefits.

Instructions to complete form:

1 Section 1: This part of the form has been pre-filled with your name, date of birth, social security number, and date of injury.

The WCA case file number does NOT need to be filled out.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION
WORKER'S AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH RECORDS

Worker/Patient FULL NAME: _____ DOB: _____ SSN: _____
FOR WCA REFERENCE ONLY: Date/s of Injury: _____ WCA Case File Number: _____

INSTRUCTIONS FOR USE: In accordance with NMSA 1978, § 52-10-1, a workers' compensation health care provider shall not require a signed medical authorization, in any form, for records that are directly related to any work place injuries or disabilities claimed by an injured worker. Costs for copying records are subject to non-clinical services fees set by the Administration, and shall not exceed $1.00 per page for the first ten (10) pages or up to twenty-cents ($0.20) for each page thereafter. A copy of this authorization may be used as an original.
Este formulario es obligatorio al presentar una queja. Si necesitas ayuda para completar este formulario, póngase en contacto con un ombudsman.

2 Section 2: Release of Health Records

* Your name has been pre-filled at the top of this section.
* Facility: This is not required to be filled out. By leaving this section blank, we will fill in the facility with either the Emergency Room, x-ray/radiology facility, orthopedic, etc.
* Service dates do not need to be specified; you can leave this field blank.

RELEASE OF HEALTH CARE RECORDS

I, (Print Worker's Name)---------- hereby authorize the following health care provider (HCP) or named facility to release my health care records for the **PURPOSE OF** facilitating and evaluating my Worker's Compensation Claim that arises from alleged workplace injuries or illnesses that occurred on the above date/s of injury.

Provider or Facility:		
Address:		

I authorize the following records released (check box, as appropriate): × **ALL RECORDS** / ☐ **SPECIFIC DATES** (provide a date range for records authorized to be released)

3 Section 3: Release of Specific Health Records.

This section can be skipped unless any of the selections apply to your specific injury and/or are requested by your adjuster.

*__Only If__ you have selected one or more boxes, you will need to sign and date this section. Do not sign otherwise.

RELEASE OF SPECIFIC HEALTH RECORDS

I FURTHER AUTHORIZE THE RELEASE OF RECORDS THAT MAY CONTAIN INFORMATION ABOUT THE FOLLOWING: (initial any that may apply).

___Treatment for alcohol and/or substance abuse ___Sexually transmitted diseases _____ HIV or AIDS
___Behavioral or Mental Health, including Psychiatric or Psychological
___Records of the Department of Health Medical Cannabis Program

_____ _____
Signature of Worker/Patient/Personal Representative Date

4 Section 4: Person/Entity Authorized to Receive Records

Please write in, New Mexico Mutual
PO Box 27810
Albuquerque, NM 87125

* This section is only to be completed by the authorized recipients.

PERSON/ENTITY AUTHORIZED TO RECEIVE RECORDS

I authorize records be released to my employer, my employer's insurer, my attorney or representative, my employer/insurer's attorney or representative, and IME providers.

(To be completed by authorized recipient/s): Records to be ☐Picked Up × Mailed ☐ Emailed ☐ Faxed ☐Other (specify) _____

Authorized Recipient/s:	New Mexico Mutual	
Address:	PO Box 27810	
	Albuquerque, NM 87125	
Fax/Email:		

5 Section 5: Complete the form by signing and dating either as the worker/patient

EXPIRATION and

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN IT AND SUCH A REFUSAL TO SIGN MAY NOT AFFECT MY TREATMENT OR SERVICES, EXCEPT AS PERMITTED BY LAW. THIS AUTHORIZATION IS LIMITED TO USE AND DISCLOSURE OF MEDICAL RECORDS AND DOES NOT WAIVE ANY PATIENT DOCTOR PRIVILEGE WITHOUT MY SEPARATE AUTHORIZATION AND CONSENT. THIS AUTHORIZATION IS TO BE VALID FOR TWO (2) YEARS FROM THE DATE OF MY SIGNATURE. I UNDERSTAND INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE RECIPIENT/S. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFIYING THE HEALTH CARE PROVIDER OR FACILITY IN WRITING; A COPY OF ANY REVOCATION SHOULD BE PROVIDED TO THE RECIPIENT/S. UPON MY REQUEST, I AM ENTITLED TO A COPY OF THE SIGNED AUTHORIZATION.

_____ _____
Signature of Worker/Patient Date

_____ _____
Signature of Personal Representative (if any) Date

_____ _____
Printed Name of Personal Representative Relationship to Worker/Patient

or their personal representative if applicable.

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