NEW MEXICO DEPARTMENT OF PUBLIC SAFETY
AUTHORIZATION TO OBTAIN HEALTH INFORMATION

This authorization allows the New Mexico Department of Public Safety (DPS) to obtain confidential health information about you. The authorization may be revoked by you. It will remain in effect indefinitely solely for purposes of obtaining information regarding your Concealed Handgun Carry Act application or permit. You are entitled to a copy of the completed authorization. There may be fees charged for any copying associated with this request. If you are a person with a disability and you require this authorization in an alternative format or require a special accommodation to complete this form, you may request assistance from staff at any DPS location.

Applicant Name Printed (*First, Middle, Last*)

1. I authorize the Department of Public Safety to obtain health information as described below.

2. I understand that any information disclosed by any provider of any kind may include information about behavioral or mental health services, and treatment for alcohol or drug/substance abuse and information obtained by the New Mexico Department of Public Safety from any other provider specifically related to the statutory purposes set out in the Concealed Handgun Carry Act at Section 29-19-1 to 29-19-13, NMSA 1978.

3. This authorization applies to any health information from any provider or any source relating to the stated purposes.

4. The health information will specifically be related to (a) adjudication of mental incompetence or any commitment to a mental institution; (b) any addiction to alcohol or controlled substances.

5. This health information shall be utilized in order to assess compliance with the purposes of the Concealed Handgun Carry Act.

STATEMENT OF UNDERSTANDING:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the New Mexico Department of Public Safety. I understand that the revocation will not apply to information that has already been obtained pursuant to this authorization. I understand that unless I revoke this authorization as stated above, this authorization will continue in full force and effect. I understand that authorizing the disclosure of this health information is voluntary. I further understand that revoking this authorization may have consequences regarding my application for a concealed handgun carry permit, or my ability to continue carrying a concealed handgun if I have already been issued a concealed handgun carry permit.

SIGNATURES

_____ _____
Signature of Applicant Date

_____ _____
Signature of Witness Date