

Reservation of Right to
Change Privacy Practices

Southern New Mexico Medical Association reserves the right to modify the privacy practices outlined in the notice.

*By signing this document you also give **Southern New Mexico Medical Association** permission to share your medical information with your spouse or significant other, one designated child/guardian or other person of your choosing. The possible medical information may include but not be limited to confirmation of appointments, prescription refills, outcomes of studies (including labs, x-rays or pathology), and any other medical information necessary to fully inform you of your medical status.*

I have reviewed this consent form and give my permission to **Southern New Mexico Medical Association** to use and disclosure my health information in accordance with it.

Patient Name: _____

Date: _____