

Authorization to Release Confidential Health Information

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Please note that each provider is a separate entity

9500 Independence Dr., Suite 700, Anchorage Alaska 99507

Phone: 907-569-3600 Fax: 907-569-3200

Name: _____ DOB: _____ SSN#: XX-XXX-_____

I consent to the **mutual exchange** by hand delivery, fax, mail or telephone of confidential information as necessary for medical treatment, payment and health care operation during the next 12 months. I authorize this office to:

Release info to: **Obtain info from:**

Name of Organization: _____

Address: _____

Phone _____ Fax: _____

Purpose of Information:

- Treatment Planning
- Personal Use
- Continued Treatment
- Legal Use
- Coordinate Treatment
- Employment Assistance
- Other _____

Information Requested:

- Treatment Dates From: _____ to _____
- Admissions/Discharge Summaries
- Medical Office Chart Notes, Consult Notes
- Medication Records
- Lab Results
- X-Ray Results
- Immunization Records
- School Records (specify) _____
- Other _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse the right to sign this authorization. I understand that I may revoke this authorization at any time. In order to revoke this authorization I must do this in writing and present this to my health care provider or designee. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact my health care provider or designee at 907-569-3600.

<u>SPECIFIC AUTHORIZATION FOR RELEASE</u>	Type of Information	Authorizing Initials
I authorize the release of the information listed at the right which requires specific consent under federal law:	Mental Health eval/treatment	
	AIDS/HIV-related	
	Substance abuse	

Client Signature (optional for minors/adults with guardians)

Date

Relative/Guardian/ Authorizes Person

Relationship

Office Use Only:

Send for Records Release Records Date Records sent: _____ By Whom: _____