ALASKA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name: _____

SSN: _____ Case # or Client ID: _____ Date of Birth: _____

Other Names Under Which Records Might Be Filed: _____

Organization Releasing Information: _____

Organization Receiving Information: _____

_____

Description of Information To Be Released: *(If substance abuse information is to be then this information must be included in the description)*

All medical records supporting disability or incapacity due to mental illness, physical illness, and/or substance abuse.

The purpose of the release of this information is: At the request of the individual

I hereby authorize the use or disclosure of my health care information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section on the back of this release, or by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires one year from the date of signature.

_____ _____

Signature of Client or Personal Representative
(Or Witness if signature is by mark)

Date

_____ _____

Printed Name of Personal Representative or Witness

Description of Personal Representative's Authority

NOTE: This authorization was revoked on: _____ *(see reverse for the revocation)*
Date

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

REVOCATION SECTION

The revocation section should only be completed IF the client wishes to revoke authorization. ***The revocation section should NOT be completed when the authorization is signed initially.***

I do hereby request that this authorization to release the information of: _____
(Printed Name of Client)
described on the reverse side of this form, be rescinded, effective _____. I understand that any
(Date)
action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
Signature of Client or Personal Representative
(Or Witness if signature is by mark)

Date

_____ _____
Printed Name of Personal Representative or Witness

Description of Personal Representative's Authority

_____
Signature of Staff