Authorization for Release of Protected or Privileged Health Information

Patient Name: _____ Date of Birth: _____
Preferred Method of Contact (phone, email, address): _____

I hereby consent to release, disclose, obtain, exchange, and/or share my health information among the following:

FROM:
Facility Address/Fax Info:
Anchorage
_____
_____
_____
_____

TO:
Specific Facility Address/Fax Info:
_____
_____
_____
_____

General Release:
☐ Yes My current and future treating providers
☐ Yes Family and/or personal representative(s):
_____

Information to be released:
☐ Yes Medical records (medical history, physical exam, consults, admission and discharge summaries)
☐ Yes Mental Health Diagnosis and/or Treatment details (Psychological/Psychiatric/Neuropsychological)
☐ Yes Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2
☐ Yes Redisclosure of Alcohol and Drug Abuse Records (including assessments and/or addendums)
☐ Yes HIV/AIDS Test Results and/or Status
☐ Yes Lab/Imaging Reports (please specify): _____
☐ Yes Other: _____

Purpose of Release:
☐ Continuing Care ☐ Personal ☐ Insurance ☐ Legal ☐ Other: _____

Method of disclosure:
☐ Verbal Discussion Only DO NOT RELEASE ANY RECORDS
☐ Fax ☐ Mail ☐ Electronic ☐ Verbal

By my signature below, I understand and consent to the following:

- My health information is protected by federal (HIPAA 45 CFR, 42 CFR Part 2) and state laws and regulations, and disclosure is allowed only with my authorization, except in limited circumstances described in the facility's Notice of Privacy Practices.
- The facility releasing the information cannot control how the recipient uses or shares the information, and cannot prevent further release by the recipient.
- I understand releases pursuant to this authorization will identify me as receiving services at this facility.
- My consent is voluntary and I may revoke this authorization at any time by giving written notice to the facility, except to the extent that action has already been taken in reliance upon it.
- I allow EOSIS owned or affiliated programs to continue to use this release upon transfer of my care to them.
- Unless revoked earlier or otherwise indicated, this authorization will expire one (1) year from the date of signing.
- The facility may charge a per page copy fee.
- A fax of photocopy that has not been altered may be considered as valid as the original.

Patient or Patient Representative: Please make sure all appropriate sections above are completed. Do not sign a blank authorization form.

_____ _____ _____
Date Signature of Patient or Authorized Person If authorized person, relationship to patient