

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION



This form must be completed in its entirety to ensure request fulfillment. Please address all shaded areas as applicable to your request.

<b>Patient Information</b> Name:	Date of Birth:
Complete Address:	Phone: Email:
<b>Release From</b> Name/Facility:	<b>Release To</b> Name/Facility:
Complete Address:	Complete Address:
Phone: Fax:	Phone: Fax:

**PURPOSE FOR REQUESTING INFORMATION** (please mark each option that applies)

<input type="checkbox"/>	Personal Use	<input type="checkbox"/>	Continuation of Care	<input type="checkbox"/>	Transfer of Care
<input type="checkbox"/>	Legal Use	<input type="checkbox"/>	Insurance Use	<input type="checkbox"/>	Other (please specify):

**I AUTHORIZE THE FOLLOWING TO BE RELEASED FROM MY MEDICAL RECORDS**  
 NOTE: Once we receive your records from another source, we cannot give them to you. We advise that you always keep your own copy for your future needs.

<input type="checkbox"/>	Last 6 months of records.	<input type="checkbox"/>	Last Year of records.	<input type="checkbox"/>	All medical records.
<input type="checkbox"/>	Other (please specify):				

**\*\*\* Some records may contain sensitive/confidential information and require a separate permissions acknowledgement. Please initial below for authorization to release these specific records.**

<input type="checkbox"/>	Alcohol/Substance Abuse Records	<input type="checkbox"/>	Genetic Records	<input type="checkbox"/>	Mental Health Records
<input type="checkbox"/>	Sexually transmitted disease or testing records.	<input type="checkbox"/>	HIV testing, status or care and treatment of AIDS.		

**Delivery Options:**  Pick-up •  Mail •  Secure E-mail •  Secure Fax •  Verbal

**LEGAL NOTIFICATIONS**

**Minors Only:** A minor patient's signature is required to release the following specific information.

Conditions relating to productive care including, but not limited to, birth control and pregnancy related services and sexually transmitted diseases, including HIV/AIDS (pertains to minors age 14 and older). • Substance Abuse diagnosis or treatment and mental health conditions (age 13 and older).

**Patient Rights:** By signing this authorization form, I am demonstrating I have read and understand the following information.

Request for copies of medical records are subject to reproduction fees in accordance with federal/state regulations. • I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment). • I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, **42 C.F.R. Part 2**, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), **45 C.F.R. pts 160 & 164**, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. • I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. • I must sign an authorization form in order to take part in a research study or to receive healthcare when the purpose is to create health information for a third party. • I may revoke this authorization at in anytime in writing. If revoked, it would not affect any actions already taken by Medical Group of Alaska based upon this authorization. I may not be able to revoke this authorization if it's purpose was to obtain insurance. Two ways to revoke this authorization are: Fill out a revocation form (available from the office), or write a letter to the office.

**You may inspect or request a copy of information that is used or disclosed under this authorization. You may refuse to sign this authorization. Once the office disclosed health information, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.**

Patient Signature (even if a minor):	Parent/Guardian Signature (if minor patient):
Patient Printed Name: Relationship to Patient: Self	Parent/Guardian Printed Name: Relationship to Patient:
Today's Date:	Today's Date:
This authorization will expire in 60 days from date signed or on _____.	Witnessed By (Name/Title): Date: