Providence Medical Group Alaska

☐ Mat-Su Behavioral Health	☐ Anchorage Behavioral Health	☐ Perinatal Support
2250 South Woodworth Loop, Suite 202	3760 Piper Street, Suite 1108	3760 Piper Street, Suite 1108
Palmer, AK 99645	Anchorage, AK 99508	Anchorage, AK 99508
Phone: (907) 761-5800	Phone (907) 212-6900	Phone (907) 212-2014
Fax: (907) 761-5801	Fax: (907) 212-6936	Fax: (907) 212-6921

Authorization to Use and Disclose Health Information

Notice: This request is not valid unless all requested information is provided.

Patient Identification:

Printed Name: _____ Date of Birth: _____

Address: _____

Home Telephone#: _____ Cell Telephone#:_____ Work Telephone#: _____

Please circle below to or from or both

Release To/From:

Name:_____ Phone:_____

Relation: _____

Address:_____ Fax:_____

Information To Be Released:

From (date) _____ To (date) _____

Please check type of information to be released:

___ History & Physical Exam ___ Medication Sheets ___ Psychiatric Evaluation
___ Discharge Summary ___ Diagnosis/Procedure Note ___ Complete Behavioral Health Record
___ Consultation Reports ___ Progress Notes ___ Laboratory Test Results
___Assessments/Evaluations ___ Scheduling/Cancelling Appointments
___ Other, (specify) _____

Receive by: __Mail __Fax __Pick-up Verbal exchange requested? __Yes ___No

Purpose of the Request:

___ Personal (at the request of the patient) ___ Treatment ___ Legal ___ Insurance ___ Government
___ Other (specify) _____

Terms

I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information.

Expiration & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to the Health Information Services Department. Unless revoked earlier, this authorization will expire 1 year from the date on which it was signed, or upon the following **date**: _____.

Re-disclosure

I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Signature: _____ **Date:** _____

If signed by legal representative, relationship to patient:

_____

Providence Medical Group

To be completed by Staff (document all requests):

Date Received _____ Date Completed _____

Materials Sent: _____ _____ _____

Completed By _____