

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#: _____

Release To/From: Name: _____ Phone: _____

Address: _____ Fax: _____

Release To/From: Name: **Providence Behavioral Medicine Group** Phone: **(907) 373-8080**

Address: **1700 East Bogard Road Suite 201, Wasilla, AK 99654** Fax: **(907) 373-8081**

Information To Be Released:

From (date) _____ To (date) _____

Please check type of information to be released:

- | | | |
|--|---|--|
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Medication Sheets | <input type="checkbox"/> Psychiatric Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnosis/Procedure Note | <input type="checkbox"/> Complete Health Record |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-ray Films/Images |
| <input type="checkbox"/> Laboratory Test Results | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Photographs, Videotapes |
| <input type="checkbox"/> Emergency Dept. Reports | <input type="checkbox"/> Assessments/Evaluations | <input type="checkbox"/> Itemized Bill |
| <input type="checkbox"/> Other, (specify) _____ | | |

Receive by: Mail Fax Pick-up Oral Exchange Only

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 six months from the date on which it was signed, or upon the following **date or event:** _____

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: _____



To be completed by PBMG Staff (document all requests):

Date Received _____ Date Completed _____

Materials Sent: _____

Completed By _____