Providence Behavioral Medicine Group

☐ Matsu Clinic	☐ Anchorage Clinic	☐ Campus Clinic
2250 South Woodworth Loop, Suite 202	3801 Lake Otis Parkway, Suite 200	3260 Providence Drive, Suite C537
Palmer, AK 99645	Anchorage, AK 99508	Anchorage, AK 99508
Phone: (907) 761-5800	Phone (907) 212-6900	Phone: (907) 212-2673
Fax: (907) 761-5801	Fax: (907) 561-8646	Fax: (907) 212-2941

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:_____

Address:_____ Fax:_____

Information To Be Released:

From (date) _____ To (date) _____

Please check type of information to be released:

___ History & Physical Exam	___ Medication Sheets	___ Psychiatric Reports
___ Discharge Summary	___ Diagnosis/Procedure Note	___ Complete Health Record
___ Consultation Reports	___ Progress Notes	___ X-ray Films/Images
___ Laboratory Test Results	___ X-ray Reports	___ Photographs, Videotapes
___ Emergency Dept. Reports	___ Assessments/Evaluations	___ Itemized Bill

___ 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: _____

_____

PROVIDENCE Behavioral Health

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

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

Date Received _____ Date Completed _____

Materials Sent: _____ _____ _____

Completed By _____