ALASKA NATIVE MEDICAL CENTER
AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

MR#:_____

Patient Name (Last, First, MI)	Date of Birth	Previous or Other Names Used
Patient Address	City, State, Zip	Telephone # Alternate #

REQUESTOR MUST PROVIDE A LEGIBLE COPY OF LEGAL IDENTIFICATION ALONG WITH THIS FORM

The information is to be disclosed by:		**And is to be provided to:**	
Name of Facility Alaska Native Medical Center Attn: HIM Dept.		Name of Person/Facility/Organization	
Address 4315 Diplomacy Drive		Address	
City, State, Zip Anchorage, AK 99508		City, State, Zip	
Phone # : 907-729-3019	Fax # : 907-729-3001	Phone # :	Fax # :

I authorize Alaska Native Medical Center to disclose the following information: □ Treatment records including clinic notes, history and physical reports, operative reports, consultations and discharge summaries
□ Records for the following dates: _____ to _____
□ Only information related to (Specify injury, accident or particular illness/treatment): _____
□ Other information specified on reverse side of this form.
□ Other information specified below.

Description of specific information to be disclosed, please place a √ *in all applicable box(es) below*:

☐	Cardiology Reports	☐	Nursing Assessments	☐	Transfer Summary
☐	Immunization Records	☐	Progress Notes	☐	Treatment Plan
☐	Lab Reports	☐	Radiology Reports	☐	Emergency Room Records
☐	Pathology Reports	☐	School Physicals	☐	Inspection with staff present *(I understand that I may not make any marks or alter the records in any way.)*
☐	Medication Lists	☐	Special Education Records		
Other (please specify:					

The information will be disclosed for the following purposes **(REQUESTOR MUST CHOOSE ONE OF THE FOLLOWING)**:
□ Customer Transferring Care to Other Hospital/Clinic □ Attorney □ School
□ Insurance □ Disability □ Law Enforcement □ Military □ Personal Use

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Parts 160 & 164) and the Privacy Act of 1974 [5USC 552a]. I understand that I may request a copy of this authorization. I understand that a photocopy/fax of this authorization is as valid as the original. I understand that health information released, if covered by federal law 42 C.F.R. Part 2 (Alcohol & drug abuse records); will continue to be protected by law from re-disclosure. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand the authorization is valid for 1 year from the signature date. I understand that I may revoke this authorization by submitting in writing a request to Health Information Services at ANMC, except to the extent that action has been taken on it

Signature: _____ Date: _____

Relationship to Patient: _____

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Office Use Only

Patient Record #:_____ **Verification Method:**_____

		Copy Process			Distribution					
Priority	**Archive**		**Date**	**Initials**		**Fax**	**Mail**	**PU**	**Date**	**Initials**

Approved by HRC: **8/4/06 revised 9/3/13**

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Complete ONLY if you would like any of the following sensitive Drug/Alcohol Treatment, Sexually Transmitted Disease, HIV/AIDS or Mental/Behavioral Health information disclosed.

***You must* INITIAL *all applicable box(es) below*:**

	Information related to drug/alcohol treatment
	Information related to treatment for any sexually transmitted disease, including HIV or AIDS
	Information related to treatment for mental/behavioral health-related illnesses:
	Intake Assessments
	Neuropsychological Assessment
	Psychiatric Assessment
	Psychological Assessment
	Treatment Plan
	Treatment Plan Review
	Behavioral Urgent Response Team (BURT)
	Medication List
	Summary of Attendance
	Summary of Participation
	Entire Mental/Behavioral Health Record
	Other Mental/Behavioral Health documentation as specified:

Signature: _____ Date: _____

Relationship to Patient: _____

NAME (Last, First, MI)	RECORD NUMBER
ADDRESS	
CITY/STATE/ZIP	DATE OF BIRTH