

**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 \checkmark in all applicable box(es) below:

| | | | | | |
|-------------------------------|----------------------|--------------------------|---------------------------|--------------------------|--|
| <input type="checkbox"/> | Cardiology Reports | <input type="checkbox"/> | Nursing Assessments | <input type="checkbox"/> | Transfer Summary |
| <input type="checkbox"/> | Immunization Records | <input type="checkbox"/> | Progress Notes | <input type="checkbox"/> | Treatment Plan |
| <input type="checkbox"/> | Lab Reports | <input type="checkbox"/> | Radiology Reports | <input type="checkbox"/> | Emergency Room Records |
| <input type="checkbox"/> | Pathology Reports | <input type="checkbox"/> | School Physicals | <input type="checkbox"/> | Inspection with staff present (I understand that I may not make any marks or alter the records in any way.) |
| <input type="checkbox"/> | Medication Lists | <input type="checkbox"/> | 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: _____

Office Use Only

Patient Record #: _____ Verification Method: _____

Priority Archive Copy Process Date Initials Distribution 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:

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