ALASKA NATIVE MEDICAL CENTER
4315 Diplomacy Dr. Anchorage, AK 99508
Email: akahimroiteam@anthc.org Phone: 907-729-3019 Fax: 907-729-3001
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AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT

Name:_____ **Birth Date:** _____ /_____ /_____

Other Names Used:_____

FROM

I request patient's information be sent by:

☐ Alaska Native Medical Center (Alaska Native Tribal Health Consortium & Southcentral Foundation)

☐ Another health care provider name here**:**_____

PROVIDE TO

Who do you want the patient information to be sent to?

Name:_____ **Phone Number:**_____

How do you want the medical information to be sent?

☐ It will be picked up.

☐ Mail to this address**:**_____

☐ Fax to**:** _____*****

☐ Email to**:**_____*****

☐ Other (describe)**:**_____

*****Sending information by Fax or Email increases privacy risks, as they involve increased risk of accidental disclosure. Information sent electronically may also be vulnerable to cyber attack.

Record Format: ☐ Paper ☐ Disc ☐ Other: _____ *Note:* If no selection is marked, paper records are mailed.

REQUESTED INFORMATION

Please check or describe the health information that you would like disclosed:

☐ Consultations	☐ Discharge Summaries	☐ History & Physical Exams
☐ Medications Records	☐ Physician Reports	☐ Nursing Notes
☐ Laboratory Results	☐ Pathology Reports	☐ Radiology & Imaging Reports
☐ Immunization Record	☐ EKG Reports	☐ Emergency Dept. Records
☐ Complete Record	☐ Sleep Study	☐ School Physical

☐ Records for the following dates or treatment**:**_____

☐ Other**:**_____

Specific Sensitive Information needs to be initialed to be disclosed:

___Mental/Behavioral Health Treatment ___Drug/Alcohol Abuse ___HIV/AIDS Information ___STD Treatment

PURPOSE

Why are you requesting this disclosure?

☐ Personal Use ☐ Legal ☐ State/Federal ☐ Insurance/Benefits ☐ Care Coordination ☐ School ☐ Other**:**_____

VALIDITY

Expiration: This authorization will expire one (1) year from the signature date, unless an alternative expiration date is provided here: ___/___/___ **Revocation:** An authorization may be revoked at any time by written notice to ANMC Health Information Management. Revocation is not effective until notice is received and is not effective regarding disclosures made before revocation and where authorization was obtained as a condition of insurance coverage.

PATIENT RIGHTS

I understand that: (1) I have a right to receive a copy of this signed authorization upon request; (2) I have a right to refuse sign this authorization - ANMC may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form; and (3) I have a right to inspect or copy my health information. I may arrange to inspect or copy information maintained by ANMC by contacting Health Information Management. I may be charged a reasonable fee for copying costs.

REQUESTOR

I authorize the disclosure of health information described above. Information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy standards, including HIPAA and the Privacy Act of 1974. A photo copy/fax of this form is as valid as the original.

Signature:_____**Date:** ____ /____/____

Print Name:_____

Relationship to Patient: ☐ Self ☐ Parent/Guardian ☐ Legally Authorized Representative ☐ Other: _____

Mailing Address:_____**City:**_____ **State:**_____**ZIP:**_____

How should we contact you if there are questions? ☐ Phone:_____ ☐ Email:_____

OFFICE USE ONLY: MRN #:_____ Verification Method:_____ □ Priority or □ Archive

Sent by: □ PU □ Mail □ Fax □ Email □ Other:_____ Date Sent: _____/_____/_____ Staff Initials:_____