

**ALASKA NATIVE MEDICAL CENTER**

4315 Diplomacy Dr. Anchorage, AK 99508

Email: [akahimroiteam@anmc.org](mailto:akahimroiteam@anmc.org) Phone: 907-729-3019 Fax: 907-729-3001



**AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

<b>PATIENT</b>	<b>Name:</b> _____ <b>Birth Date:</b> ____ / ____ / ____ <b>Other Names Used:</b> _____															
<b>FROM</b>	<b>I request patient's information be sent by:</b> <input type="checkbox"/> Alaska Native Medical Center (Alaska Native Tribal Health Consortium & Southcentral Foundation) <input type="checkbox"/> Another health care provider name here: _____															
<b>PROVIDE TO</b>	<b>Who do you want the patient information to be sent to?</b> <b>Name:</b> _____ <b>Phone Number:</b> _____ <b>How do you want the medical information to be sent?</b> <input type="checkbox"/> It will be picked up. <input type="checkbox"/> Mail to this address: _____ <input type="checkbox"/> Fax to: _____ * <input type="checkbox"/> Email to: _____ * <input type="checkbox"/> Other (describe): _____ <small>*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.</small> <b>Record Format:</b> <input type="checkbox"/> Paper <input type="checkbox"/> Disc <input type="checkbox"/> Other: _____ <i>Note: If no selection is marked, paper records are mailed.</i>															
<b>REQUESTED INFORMATION</b>	<b>Please check or describe the health information that you would like disclosed:</b> <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Consultations</td> <td><input type="checkbox"/> Discharge Summaries</td> <td><input type="checkbox"/> History &amp; Physical Exams</td> </tr> <tr> <td><input type="checkbox"/> Medications Records</td> <td><input type="checkbox"/> Physician Reports</td> <td><input type="checkbox"/> Nursing Notes</td> </tr> <tr> <td><input type="checkbox"/> Laboratory Results</td> <td><input type="checkbox"/> Pathology Reports</td> <td><input type="checkbox"/> Radiology &amp; Imaging Reports</td> </tr> <tr> <td><input type="checkbox"/> Immunization Record</td> <td><input type="checkbox"/> EKG Reports</td> <td><input type="checkbox"/> Emergency Dept. Records</td> </tr> <tr> <td><input type="checkbox"/> Complete Record</td> <td><input type="checkbox"/> Sleep Study</td> <td><input type="checkbox"/> School Physical</td> </tr> </table> <input type="checkbox"/> Records for the following dates or treatment: _____ <input type="checkbox"/> Other: _____ <b>Specific Sensitive Information needs to be initialed to be disclosed:</b> ___Mental/Behavioral Health Treatment ___Drug/Alcohol Abuse ___HIV/AIDS Information ___STD Treatment	<input type="checkbox"/> Consultations	<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> History & Physical Exams	<input type="checkbox"/> Medications Records	<input type="checkbox"/> Physician Reports	<input type="checkbox"/> Nursing Notes	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Radiology & Imaging Reports	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> EKG Reports	<input type="checkbox"/> Emergency Dept. Records	<input type="checkbox"/> Complete Record	<input type="checkbox"/> Sleep Study	<input type="checkbox"/> School Physical
<input type="checkbox"/> Consultations	<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> History & Physical Exams														
<input type="checkbox"/> Medications Records	<input type="checkbox"/> Physician Reports	<input type="checkbox"/> Nursing Notes														
<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Radiology & Imaging Reports														
<input type="checkbox"/> Immunization Record	<input type="checkbox"/> EKG Reports	<input type="checkbox"/> Emergency Dept. Records														
<input type="checkbox"/> Complete Record	<input type="checkbox"/> Sleep Study	<input type="checkbox"/> School Physical														
<b>PURPOSE</b>	<b>Why are you requesting this disclosure?</b> <input type="checkbox"/> Personal Use <input type="checkbox"/> Legal <input type="checkbox"/> State/Federal <input type="checkbox"/> Insurance/Benefits <input type="checkbox"/> Care Coordination <input type="checkbox"/> School <input type="checkbox"/> Other: _____															
<b>VALIDITY</b>	<b>Expiration:</b> This authorization will expire one (1) year from the signature date, unless an alternative expiration date is provided here: ____/____/____ <b>Revocation:</b> 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.															
<b>PATIENT RIGHTS</b>	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.															
<b>REQUESTOR</b>	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.  <b>Signature:</b> _____ <b>Date:</b> ____ / ____ / ____ <b>Print Name:</b> _____ <b>Relationship to Patient:</b> <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Legally Authorized Representative <input type="checkbox"/> Other: _____ <b>Mailing Address:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>ZIP:</b> _____ <b>How should we contact you if there are questions?</b> <input type="checkbox"/> Phone: _____ <input type="checkbox"/> Email: _____															