

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: HIS Dept.		Name of Person/Facility/Organization	
Address 4315 Diplomacy Drive		Address	
City, State, Zip Anchorage, AK 99508		City, State, Zip	
Phone # : 907-729-3000	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.

<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>(I understand that I may not make any marks or alter the records in any way.)</i>
<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** _____ **Distribution** _____
 _____ Date Initials Fax Mail PU Date Initials

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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	DATE OF BIRTH