State of Alaska

Department of Health and Social Services
Division of Health Care Services
4501 Business Park Blvd., Suite 24
Anchorage, AK 99503
(907)334-2400
350 Main Street, Number 412
Juneau, AK 99811

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____

SSN: _____ Record # or Other ID: _____ Date of Birth: _____

Other Names Under Which Records Might Be Filed: _____

Person/Organization Releasing Information: _____

Person/Organization Receiving Information: (*include address if needed*) _____

_____

Description of Information To Be Released: *(If substance abuse information is to be released from a federally assisted substance abuse treatment center, then this information must be included in the description)*

_____

_____

The purpose of the release of this information is: _____

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section on the back of this release, or by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event: _____

_____ _____
Signature of Client or Personal Representative (Or Witness if signature is by mark) | Date

_____ _____
Printed Name of Personal Representative or Witness | Description of Personal Representative's Authority

NOTE: This authorization was revoked on: _____ *(see attached revocation)*
Date

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

INSTRUCTIONS:

The elements of this form described below (1-5) and marked with an asterisk (*) MUST BE COMPLETED. There are NO exceptions. Incomplete authorization forms are invalid and WILL NOT BE PROCESSED!

1. **Client Information ***: Enter the Name, SSN, Case # or Client ID, and Date of Birth (if known) of the individual whose information (PHI) is being released or requested. At least one identifier other than name must be present – e.g. SSN or DOB or Case # or Client ID

2. **Organization Releasing and Receiving Information ***: Enter "DHSS" and/or "Division Name" or "Program Name" ONLY on either the Releasing line or Receiving line depending on whether the Department or Division is receiving information or releasing information. ***DO NOT enter specific DHSS employee names!*** The client or client's representative should indicate a specific name (and address, if known) of the individual(s) or organization(s) receiving or releasing the information. Multiple individuals/organizations may be specified on a single authorization if they are ALL receiving the same information and are clearly specified. Use additional authorizations if individuals/organizations are receiving different information or if there is not enough room on a single authorization to clearly specify multiple individuals/organizations on the Receiving Information lines.

3. **Description of Information to be Released ***: A specific description of the information that is being requested or released should be indicated. Detail is not required, but is preferred. For example, *"Medical and mental health records"* rather than "*All information you have*". If alcohol or other substance abuse information is being released or requested, this must be explicitly stated in the description. For example, *"Medical and mental health records, including alcohol or substance abuse records"*.

4. **Expiration Date/Event ***: Enter a date or event that is reasonable and acceptable to the client or client's representative. For instance, "*One year from the date of this authorization*" is generally accepted as a reasonable expiration date.

5. **Signatures & Dates ***: The individual whose PHI is being released or requested should sign and date the form. If the individual is a minor, or is otherwise not able to sign the form, the individual's authorized representative or witness should sign and date it. If an authorized representative is signing the form on behalf of the client, the representative's "legal authority" to act on the part of the individual must be verified first and then described in the appropriate space. Legal authority includes but is not limited to a parent who signs the form for a minor child or an individual who has power of attorney over the affairs of the individual whose PHI is being released or requested.

6. **Revocation Date**: The revocation date on the reverse side of this form does NOT need to be completed UNLESS the individual has revoked this authorization using form 06-5872 Revocation of Authorization. If revoked, a copy of the revocation should be attached to this form & the date of revocation noted of the front of this form.

7. **ALL authorization forms MUST be retained for SIX (6) YEARS from the date of signature**. This form should be stored in the client file, if one is maintained. Some programs have procedures requiring the form, or a copy of the form be retained solely or additionally by the Division Privacy Official. Please refer to the appropriate Division or Program specific procedures or inquire with your Division Privacy Official regarding any additional retention requirements of authorization forms.

8. If requested, provide a copy of this authorization to the client or client's representative.

QUESTIONS?
Contact the Division of Health Care Services Privacy Official at (907) 334-2400 or the DHSS Privacy Official at (907)465-4722 with any concerns you may have.

FOR DHSS & BUSINESS ASSOCIATE USE ONLY

Use this section to document ALL disclosures made by DHSS or business associates based on this authorization. Please supply the information below detailing information about the disclosures that may not be adequately described the front of this authorization. For instance, if Description of Information To Be Released on the front states "*All information you have on me"* – then completely describe the data that was actually disclosed, such as "*Medicaid eligibility and disability information from 1993 - 2001*" or "*Immunization data from 2001 - 2003*". Indicate the actual date(s) of disclosure(s) and the name and division of the employee(s) releasing the data. Attach additional documentation if necessary.

Disclosure Date	Disclosed By (Name/Division)	Detailed Description of Information Disclosed