State of Alaska
Department of Health and Social Services
Division of Public Health
3601 C Street, Suite 322
Anchorage, AK 9950-5923
Fax # 907-754-3525

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____ SSN: _____

Alias which records might be filed: _____

I Request and authorize: **State of Alaska Genetics & Metabolic Clinic** to release health care information of the patient named above to:

Name: _____ Phone: ( ) _____ -_____ Fax: ( ) _____- _____

Address: _____ City: _____ State: _____ Zip Code: _____

For date(s) of service: _____to_____

I authorize for my information to also be released to:

□ Public Health Nursing □ Oregon Health & Science University □ Seattle Children's Hospital
□ Stone Soup Group □ Providence Alaska Medical Center- Neurodevelopmental/Autism Center

This request and authorization applies to:

□ Prenatal Medical Records	□ Radiology Films	□ Psychological testing/ Assessment	□ Medical records of visits
□ Genetic Test Reports	□ Speech/Language Reports	□ Early Intervention Services Plan	□ Discharge Summary
□ Cardiology Reports	□ Physical Therapy Reports	□ Nutrition Reports	□ Ophthalmology Reports
□ Growth Charts	□ Audiology Reports	□ Educational Testing/Records	□ **Any and All Records**
□ Lab Reports	□ Occupational Therapy Reports	□ Neuro-development/ Assessment	

I acknowledge that the information to be released MAY INCLUDE material that is protected by Federal Law. My initials and my signature below authorize release of the following type of information.

_____Drug/Alcohol Abuse Information _____ Mental Health _____ HIV Information

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.

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.

_____ _____
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 reverse or attached revocation)*
Date

REVOCATION SECTION *

I do hereby request that this authorization to release the information of: _____
(Printed Name of Client)

described on the reverse side of this form, be rescinded, effective _____. I understand that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
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

_____
Signature of Staff

* This Revocation Section must appear on the reverse side of DHSS Authorization for Release of Information 06-5870 (03/03) and is invalid if used separately. If a separate form is required, use DHSS Revocation of Authorization for Release of Information 06-5872 (03/03). If this revocation section has been completed and signed, please note the date of the revocation on the reverse side of this form in the space provided.