STATE OF ALASKA

Department of Health and Social Services
Division of Senior & Disabilities Services
400 Gambell Street, Suite 303 ● Anchorage, Alaska 99501
(907) 269-3680 ● 1-800-478-6065 ● FAX (907) 269-2045

AUTHORIZATION FOR RELEASE OF INFORMATION

Name:_____
Record # or Other ID: _____Date of Birth: _____
Other Names under which records might be filed:_____
Person/Organization Releasing Information: _____
Person/Organization Receiving Information: _____
_____
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 effect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information *may* 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NOTE: This authorization was revoked on: _____ *(see reverse or attached revocation statement)*
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.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

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