ALPENGLOW
WOMEN'S HEALTH

Authorization for Release of Protected Health Information

This form must be completed in its entirety to ensure request fulfillment. Please address all areas as applicable to your request.

Patient Information

Patient Name _____ Date of Birth _____

Complete Address _____ Phone _____

_____ Email _____

Release From

Name / Facility _____

Complete Address _____

_____

Phone _____

Fax _____

Release To

Name / Facility _____

Complete Address _____

_____

Phone _____

Fax _____

Purpose for Requesting Information *(please mark each one that applies)*

◯ Personal Use ◯ Continuation of Care ◯ Transfer of Care ◯ Legal Use

◯ Insurance Use ◯ Other *(Please Specify):* _____

I authorize the following to be released from my medical records

Note: Once we receive your records from another source, we cannot give them to you. We advise that you always keep your own copy for your future needs.

◯ Last 6 months of records ◯ Last pap smear and labs ◯ All surgeries

◯ Other *(Please Specify):* _____

Some records may contain sensitive/confidential information and require a separate permissions acknowledgment. Please initial below for authorization to release these specific records.

____ Alcohol/Substance Abuse Records ____ Genetic Records ____ Mental Health Records

____ Sexually transmitted disease or testing records ____ HIV testing, status or care and treatment of AIDS

Delivery Options

◯ Pick Up ◯ Mail ◯ Secure E-mail ◯ Secure Fax ◯ Verbal

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Legal Notifications

Minors Only: *A minor patient's signature is required to release the following specific information.*

- Conditions relating to productive care including, but not limited to, birth control and pregnancy related services and sexually transmitted diseases, including HIV/AIDS (pertaining to minors age 14 and older). Substance Abuse diagnoses or treatment and mental health conditions (age 13 and older).

Patient Rights: *By signing this authorization form, I am demonstrating and I have read and understand the following information.*

- Request for copies of medical records are subject to reproduction fess in accordance with federal/state regulations.
- I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment)
- I understand that my substance use disorder records are protected under the Federal regulation governing Confidentiality and Substance Use Disorder Patient Records, **42 C.F.R. Part 2**, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), **45 C.F.R. pts 160 & 164**, and cannot be disclosed without my written consent unless otherwise provided for by regulations.
- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
- I must sign an authorization form in order to take part in a research study or to receive healthcare when the purpose is to create health information for a third party.
- I may revoke this authorization at anytime in writing. If revoked, it would not affect any actions already taken by Medical Network of Alaska based upon this authorization. I may not be able to revoke this authorization if it's purpose was to obtain insurance. Two ways to revoke this authorization are: Fill out a revocation form (available from the office), or write a letter to the office.

You may inspect or requires a copy of information that is used or disclosed under this authorization. You may refuse to sign this authorization. Once the office disclosed health information, the person or organization that receive it may re-disclose it and privacy lays may no longer protect it.

Patient Signature: _____
(even if a minor)

Patient Printed Name: _____

Relationship to Patient: Self

Today's Date: _____

This authorization will expire 60 days from date signed or on:

_____

Parent/Guardian Signature: _____
(if minor patient)

Parent/Guardian Printed Name: _____

Relationship to Patient: _____

Today's Date: _____

Witnessed By (Name/Title): _____

Date: _____