



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I understand the following:

- The following form must be completed in its entirety to ensure request fulfillment. Please address all areas as applicable to your request.
- **Minors:** A minor patient's signature is required to release the following information; Conditions related to, but not limited to, birth control and pregnancy related services and sexually transmitted diseases, including HIV/AIDS (14 years or older), and/or Substance Abuse diagnosis or treatment and mental health conditions (13 years or older).
- **Patient Rights:**
 - By signing this authorization form, I am demonstrating that I have read and understand the following information: Request for copies of medical records are subject to reproduction fees in accordance with federal/state regulations. I understand that my substance use disorder records are protected under the Federal regulations governing confidentiality and substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent, unless otherwise provided for by the regulations.
 - I understand that the information used or disclosed may be subject to re-disclosure by the person or class or persons or facility receiving it and would then no longer be protected by federal privacy regulations.
 - I must sign an authorization form 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 Group of Alaska based upon this authorization. I may not be able to revoke this authorization if its purpose were to obtain insurance. Ways to revoke this authorization are: Fill out a revocation form (available from the office) or write a letter to the office stating that you want to revoke this form.
 - You may inspect or request a copy of information that is used or disclosed under this authorization. You may refuse to sign this authorization. Once the office discloses health information, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.
- Records received from another source cannot be given to you. We advise that you always keep your own copy for future needs.



AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION

Patient Information:

Name: Date of Birth: Address: Phone: City/State: Social Security:

Authorization is hereby granted for release of information

Release From: Release To: Name/Facility: Address: Phone: Fax:

We do not send to patient's personal fax numbers

Purpose for requesting information: Personal Continuation of care Transfer of Care Legal Insurance Other

I authorize the following information to be released from my records: Last 3 years Last 5 years All medical records Other

Delivery Options: Pick-up Mail CD

Some records may contain extremely confidential information. I do consent to the release of the following information relating to (If left blank, authorization to release information is Not assumed) Patients age 13-17 must initial to consent.

*Alcohol/Substance abuse/testing (initials) *HIV testing, status or care and treatment for AIDS (initials) *Mental Health conditions/Psychotherapy notes and Psychological Evaluations (initials) *Sexually transmitted disease/testing (initials) *Genetic records (initials)

Patient Rights: By signing this authorization form, I understand that:

- Requests for copies of medical records subject to reproduction fees in accordance with federal/state regulations. I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). I do have to sign an authorization form: To take part in a research study or to receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If revoked, it would not affect any actions already taken by Medical Group 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 request a copy of information that is used or disclosed under this authorization. You may refuse to sign this authorization. Once the office discloses health information, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.

Patient, Parent or Guardian's Signature (Patient's age 13-17 must also sign)

Printed Name

Today's Date Relationship to Patient

Witnessed by

This consent will expire on _____ or 60 days after date signed.