FREEDOM BEHAVIORAL HEALTH SOLUTIONS
DTMS | VR/AR THERAPY | MED MANAGEMENT

10928 Eagle River Road Suite 254
Eagle River, Alaska, 99577
(907) 696-0221
infoer@freedombhs.com
www.freedombhs.com

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I, _____ (patient name) _____ (DOB), hereby authorize the release or use my health information as disclosed below.

My Health Information May Be Sent by: (Please list Provider's Name, Address and/or Fax #)

_____

My Health Information May Be Received by: (Please list Provider's Name, Address and/or Fax #)

_____

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Reason for Disclosure: _____

Please Circle if you would like your information disclosed via Hard/Printed Copy **or** Electronic/PDF copy

Please Check What You Would Like To Send and/or Request At This Time:

- □ Complete Health Record
- □ Email/Phone Communication
- □ Specific Clinic Note (Please list date of visit):_____
- □ A Written Treatment Summary

I Understand the Following:

- I understand the information disclosed may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.
- I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from when it is received in this office and will not apply retroactively.
- I understand that not signing this form (or cancellation of authorization) will not prevent me from receiving any treatment from Freedom BHS.
- I understand that this Release of Information Authorization will expire in one year unless otherwise listed here:_____

Patient/Guardian PRINTED Name:_____

Patient/Guardian SIGNATURE:_____ Date:_____