BOREALIS BEHAVIORAL HEALTH, LLC

634 S. Bailey, #207 Palmer, AK 99645
907/917-4151 Fax# 907/600-1406

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please be aware that **you must fill out this form completely** before records will be released.

Client's Name:_____Birthday: _____ SS#: _____

Former Names:_____Phone Number: _____

Please list the **Name, address, phone number and fax number** of the following:

I authorize: (where information is stored)	To release to: (where information should be sent)
_____	_____
_____	_____
_____	_____
_____	_____

Specific dates of service or conditions to be released: _____

Information requested to be released:

(*Initial all that apply)

1. Complete Record	_____	1. Further Treatment/ COC	_____
2. Psychiatric Evaluation	_____	2. Personal Use	_____
3. Initial Assessment/Treatment Plan	_____	3. Legal Guardian Information	_____
4. Psychiatric/Mental Hlth Notes	_____	4. School	_____
5. Psychological/Mental Hlth Notes	_____	5. Social Security Disability	_____
6. Lab/X-ray Reports	_____	6. Insurance Claims	_____
7. Medication List	_____	7. WorkersCompenstion	_____
8. Discharge Summary	_____	8. Legal Request	_____
9. Substance Abuse Records	_____	9. Other _____	
10. Verbal Information	_____	_____	

For the purpose of: (please be specific)

11. OTHER _____

Means of Delivery: Pick-Up ☐ Mail ☐ Fax *(not most reliable method)* ☐

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

____ Mental health, if any _____ Drug abuse, if any (signature of minor required by law)

_____

I understand that the provider will not condition my treatment on whether I provide authorization for the requested use or disclosure. I specifically authorize any current employee of Borealis Behavioral Health, LLC to disclose my protected health information as described on this form to the recipients listed above. **This consent for release of confidential information expires in 90 days**. I understand I have the right to inspect or copy my protected health information to be used or disclosed as permitted under federal law and I have the right to refuse to sign this authorization. I understand I may revoke this authorization at any time, except to the extent that action has already been taken in compliance with the consent, by submitting a Revoke Authorization Form, which is available and must be returned to Borealis Behavioral Health, LLC.

_____		_____	
Signature/Patient	Date	Witness	Date
_____		_____	
Signature/Parent or Guardian	Date	Clinician's Approval	Date

This information has been disclosed to you from records whose confidentiality if protected from disclosure by state and federal law, 45 CFR Part 2 prohibits you from making any further disclosures of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is not sufficient for this purpose.

NOTE: PER HIPAA, RECORDS MUST BE RELEASED WITHIN 30 DAYS FROM DATE ON ROI OR NOTIFACATION OF DELAY MUST BE GIVEN.

Form revised 12/15