Peak Counseling
(A Company of Eric Unruh Counseling, LLC)
17105 Park Place Street
Eagle River, AK 99577
907-622-1002
Fax #: 907-622-8808

Authorization to Release Confidential Information

1. PATIENT INFORMATION

Patient last name _____ First name _____ MI _____
Date of birth _____
Patient former name (if any) _____ _____
Patient address _____
Patient e-mail _____
Patient home phone _____ Work phone _____ Cell phone _____

2. RECIPIENT AUTHORIZATION

I, _____, do hereby authorize **Peak Counseling**
(Patient name or representative) (Provider)

to release my patient information to: _____
(Name of person/facility to receive mental health record)
Street address _____
Phone _____Fax: _____

3. INFORMATION TO BE RELEASED

□ My entire mental health record
OR
□ Assessment
□ Chart Notes / Progress Notes
□ Treatment Plan
□ Discharge Summary
□ Other : _____

4. DATE(S) OF INFORMATION TO BE DISCLOSED:

From _____ to _____
If left blank, information from the past two (2) years will be disclosed.

5. INCLUSION OF PRIVILEDGED INFORMATION:

____ By initialing, I understand these records may contain information regarding mental health and/or drug/alcohol abuse.

(I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.)

6. REVOCATION:

Would you like to set a date to revoke this release of information? No___ Yes___
If yes, date to be revoked: _____

7. SIGNATURE OF PATIENT

(I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.)

Client or Guardian's Signature: _____

Date: _____

Print Name: _____

If signed by a personal/legal representative, state your relationship to patient and/or reason and legal authority for signing:
Patient is: □ minor □ incompetent □ disabled □ deceased
Legal authority: □ parent □ legal guardian □ next of kin of deceased

Signature of Staff Witness Attesting to Identity and Authority _____

Date_____