Authorization to Release Confidential Health Information

Elizabeth deSchweinitz M.D, Dwayne E Trujillo M.D, Candace Carson-McCollum, ANP
Please note that each provider is a separate entity
9500 Independence Dr., Suite 700, Anchorage Alaska 99507
Phone: 907-569-3600 Fax: 907-569-3200

Name:_____ DOB:_____ SSN#: XX-XXX-_____

I consent to the **mutual exchange** by hand delivery, fax, mail or telephone of confidential information as necessary for medical treatment, payment and health care operation during the next 12 months. I authorize this office to:

[ ] Release info to: **[ ] Obtain info from:**

Name of Organization:_____

Address: _____

Phone_____ Fax:_____

Purpose of Information:

[ ] Treatment Planning
[ ] Personal Use
[ ] Continued Treatment
[ ] Legal Use
[ ] Coordinate Treatment
[ ] Employment Assistance
[ ] Other _____

Information Requested:

Treatment Dates From: _____ to _____
[ ] Admissions/Discharge Summaries
[ ] Medical Office Chart Notes, Consult Notes
[ ] Medication Records
[ ]] Lab Results
[ ] X-Ray Results
[ ] Immunization Records
[ ] School Records (specify)_____
[ ] Other_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse the right to sign this authorization. I understand that I may revoke this authorization at any time. In order to revoke this authorization I must do this in writing and present this to my health care provider or designee. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact my health care provider or designee at 907-569-3600.

SPECIFIC AUTHORIZATION FOR RELEASE

I authorize the release of the information listed at the right which requires specific consent under federal law:

Type of Information	Authorizing Initials
Mental Health eval/treatment	(Allows the releasing facility to release all records)
AIDS/HIV-related	
Substance abuse	

_____ _____
Client Signature (optional for minors/adults with guardians) Date

_____ _____
Relative/Guardian/ Authorizes Person Relationship

Office Use Only:
[ ] Send for Records [ ] Release Records Date Records sent:_____ By Whom:_____