Authorization for Release of Information

Anchorage Neighborhood Health Center
1217 E. 10th Avenue, Anchorage, AK 99501
Phone: 907-257-4600 Fax: 907-257-4644

Patient Name: ____ DOB: ________-________-________

SS# ________-__________-__________ Phone: ____________________ Evening Phone: ____________________

Address: ________________________________ City: __________________ State: _______ Zip: ____________

I, (___Patient ____Parent _____Legal Guardian) hereby authorize **Anchorage Neighborhood Health Center** to:

☐ Release Information to: ☐ Obtain Information from:

Name: ____

Address: ________________________________ City __________________ State _______ Zip ____________

Phone: ________________________________ Fax: ________________________________

Please initial
INFORMATION TO BE RELEASED **Dates:**

Initial	Information	Dates
______	History and Physical	__________
______	Progress Notes	__________
______	Lab Reports	__________
______	X-ray Reports	__________
______	Medication List	__________
______	Immunization Records	__________
______	Other (Please specify) ______________________________	

Please initial to authorize release of information relating to:

_____ **Substance or Alcohol abuse**

_____ **Mental Health**

_____ **HIV related information**

X ______________________________ __________
Signature of Patient or Legal Guardian **Date**

PURPOSE OF DISCLOSURE:

☐ Changing Physicians ☐ Personal Use ☐ Consultation/Second Opinion
☐ Continuing Care ☐ Insurance ☐ School
☐ Legal ☐ Worker's Compensation
☐ Other (Please specify) ____

I understand that authorizing the disclosure of this health information is voluntary. I understand that this authorization will expire **90 days** after I have signed this form. I understand that I may revoke this authorization at any time by notifying **Anchorage Neighborhood Health Center** in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer be protected by Federal privacy regulations. By authorizing this release of information, my treatment, health care, and payment for my heath care will not be affected if I do not sign this form. I understand that I will get a copy of this form after I sign it. In order to offset the cost of maintaining and producing copies of the medical record, **ANHC** does charge for copies. There is no charge for medical records if copies are sent to other health care facilities for ongoing care or follow up treatment.

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from patient records whose confidentiality is protected by Federal Regulations (42 CFR Part 2) prohibiting you from making any further disclosure of this information except with the specific written consent of the person of to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

______________________________ __________ OR ______________________________ __________
Patient Signature Date Parent/Legal Guardian Date

______________________________ __________ ______________________________
Witness Date Relationship to Patient

For Office Use Only

Date Request Filled: ________________ By: ______________________________

Signed copy must be given to patient: ☐ Yes ☐ No, Patient refused copy