

Providence Medical Group Alaska

Mat-Su Behavioral Health
2250 South Woodworth Loop, Suite 202
Palmer, AK 99645
Phone: (907) 921-5050
Fax: (907) 761-5801

Anchorage Behavioral Health
3760 Piper Street, Suite 1108
Anchorage, AK 99508
Phone (907) 212-6900
Fax: (907) 212-6936

U-Med Behavioral Health
3260 Providence Drive, Suite C537
Anchorage, AK 99508
Phone (907) 212-2673
Fax: (907) 212-2941

Authorization to Use and Disclose Health Information

Notice: This request is not valid unless all requested information is provided.

Patient Identification:

Printed Name: Date of Birth:

Address:

Home Telephone#: Cell Telephone#: Work Telephone#:

Please circle below to or from or both

Release To/From: Name: Phone:

Relation:

Address: Fax:

Information To Be Released:

From (date) To (date)

Please check type of information to be released:

- History & Physical Exam Medication Sheets Psychiatric Reports
Discharge Summary Diagnosis/Procedure Note Complete Behavioral Health Record
Consultation Reports Progress Notes Laboratory Test Results
Assessments/Evaluations Scheduling/Cancelling Appointments
Other, (specify)

Receive by: Mail Fax Pick-up Verbal exchange requested? Yes No

Purpose of the Request:

Personal (at the request of the patient) Treatment Legal Insurance Government
Other (specify)

Terms

I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information.

Expiration & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to the Health Information Services Department. Unless revoked earlier, this authorization will expire 1 year from the date on which it was signed, or upon the following date:

Re-disclosure

I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Signature: Date:

If signed by legal representative, relationship to patient:



To be completed by Staff (document all requests):
Date Received Date Completed
Materials Sent:
Completed By