Providence Medical Group Alaska

☐ **Mat-Su Behavioral Health**
2250 South Woodworth Loop, Suite 202
Palmer, AK 99645
Phone: (907) 761-5800
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
___ Discharge Summary
___ Consultation Reports
___ Assessments/Evaluations
___ Medication Sheets
___ Diagnosis/Procedure Note
___ Progress Notes
___ Scheduling/Cancelling Appointments
___ Psychiatric Reports
___ Complete Behavioral Health Record
___ Laboratory Test Results
___ 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 ______________________________