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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **AUTHORIZATION FOR RELEASE OF CLIENT RECORDS** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Client Name: | | | | | | | | | | | | | Other Names Used: | | | | | | | | | | | | |
| DOB: | Last four digits of SS#: | | | | | | | Chart #: | | | | | Name of Parent/Legal Guardian: | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client Information requested for release:** | | | | | | | | | | | | | **Purpose of the information:** | | | | | | | | | | | | |
| 🞏 Continuation of Care  🞏 Legal  🞏 Insurance | | | | | | | | 🞏 Personal at request of patient  🞏 Other: | | | | |
| **Dates of Records requested** | | | | | From: | | | | | End: | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please initial if you also want the following information released: This information is protected by federal law (CFR 42 part 2) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Substance Abuse Information | | | | | | |  | HIV / AIDS Information | | | | | | | | |  | Mental Health Information | | | | | |  |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 🞏 **RECORDS IN:** I AUTHORIZE THE FOLLOWING ORGANIZATION TO RELEASE RECORDS TO MOA DHHS: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Organization releasing records to MOA DHHS: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Release Client Records to:  🞏 Disease Prevention & Control Clinic 🞏 Reproductive Health Clinic 🞏 Immunizations Clinic | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fax to: (907) 249-7992 | | | | OR | | Mail to: Municipality of Anchorage, DHHS Medical Records PO Box 196650, Anchorage, AK 99519-6650 | | | | | | | | | | | | | | | | Attention: | | | |
| ⭬ OR⭪ | | | | | | | | | | | | | | | | | | | | | | | | | |
| 🞏 **RECORDS OUT:** I AUTHORIZE MOA DHHS TO RELASE RECORDS TO THE FOLLOWING PERSON/ORGANIZATION: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name / Organization receiving records from MOA DHHS: | | | | | | | | | | | | | | | Mailing Address: | | | | | | | | | | |
| Phone #: | | | Fax #: | | | | | | Attention: | | | | | |
| I hereby authorize the use and disclosure of my health information as described above. This authorization is voluntary and I can revoke this release at any time by notifying DHHS in writing. I also understand that information already released does not apply. I further acknowledge that the information to be released may include information that is protected by Federal Law and that the recipient must continue to keep this information confidential. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **This Authorization expires *one year* from the date of signature, OR** | | | | | | | | | | | | | |  | | | | | **date specified (less than one year)** | | | | | | |
|  | | | | | | | | | | |  | |  | | | | | | | | | | | | |
| **Signature of Client / Guardian or Representative** | | | | | | | | | | |  | | **Date** | | | | | | | | | | | | |
|  | | | | | | | | | | |  | |  | | | | | | | | | | | | |
| **Print Client / Guardian or Representative Name** | | | | | | | | | | |  | | **Description of Representative’s Authority** | | | | | | | | | | | | |
|  | | | | | | | | | | |  | |  | | | | | | | | | | | | |
| **Revocation Section** | | | | | | | | | | | | | | | | | | | | | | | | | |
| I hereby request that this authorization to release the information of: | | | | | | | | | | | |  | | | | | | | | | | | (printed name of client) | | |
| described on the form above, be revoked, effective (Date) | | | | | | | | | | | | |  | | |  | | | |  | | | | | | |
|  | | | | | | | | | | |  | |  | | | | | | | | | | | | |
| **Signature of Client / Guardian or Representative** | | | | | | | | | | |  | | **Date** | | | | | | | | | | | | |
|  | | | | | | | | | | |  | |  | | | | | | | | | | | | |
| **Print Client / Guardian or Representative Name** | | | | | | | | | | |  | | **Description of Representative’s Authority** | | | | | | | | | | | | |
| **Signature of Staff:** |  |  | | | | | | | | |  | | | | | | | | | | | | | | |