ALASKA PSYCHIATRIC INSTITUTE

Return Address: Health Information Management Services, Alaska Psychiatric Institute, 2900 Providence Drive, Anchorage, Alaska 99508
Phone: (907) 269-7100 Fax #: (907) 269-7129

Section 1

I, _____ DOB: _____ SS#: _____
hereby authorize:

_____ (Name of Person/Agency) ☐ To Release to _____ (Name of Person/Agency)

_____ (Address) ☐ To Exchange with _____ (Address)

_____ (City, State, Zip Code) ☐ Exchange Verbal Information _____ (City, State, Zip Code)

Section 2

The following specific information:

☐ Admission Assessment/Data Base ☐ Social History ☐ Lab
☐ Discharge Summary ☐ History & Physical ☐ X-Ray
☐ Nursing Assessment ☐ Psychological Evaluation ☐ Rehabilitation Assessments
☐ Other: _____

for care received from: _____ to _____

Section 3

The purpose of the release of this information is:

☐ Sharing with other health care providers as needed ☐ My personal records ☐ Legal
☐ Other – Please specify _____

I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Exchange of information ensures continuity of care between providers. By not sharing information, my health care could be compromised.

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential.

This authorization expires on the following date or event: _____ or 90 days from the date of signature if no other date or event is indicated.

_____ / _____ _____ / _____
(Signature of Witness) (Date) (Signature of Patient/Guardian) (Date)

NOTE: This authorization was revoked on: _____ _____ / _____
(See reverse side or attached revocation) (Relationship to Patient) (Date)

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Identification

AUTHORIZATION FOR RELEASE OF INFORMATION

IMPORTANT INFORMATION FOR COMPLETING THIS FORM

INSTRUCTIONS:

1. Enter the Name, Date of Birth and SS# of the individual whose Protected Health Information (PHI) is being released or requested. **This section is required and the request will be denied if not completed.**
2. Name of Person / Agency Releasing Information: Enter API on the left hand side if we are expecting to **release and / or exchange** PHI. Enter API on the right hand side if we are expecting to **receive and / or exchange** PHI. If verbal information is all that is requested and we will not be asking for or sending medical records, please check "Exchange Verbal Information Only." **This section is required and the request will be denied if not completed.**
3. Description of Information to be Released: Include specific description of information that is being requested or released. Please use descriptions provided when possible, i.e. Admission Assessment/Database, Social History, etc. If you need to request the entire medical record, state "Entire Medical Record." Enter date of care received from: ____ to ____. If dates of service are known please enter this information. If we truly need "all dates" then enter "all dates". We should only request the minimum information necessary to fulfill our needs. **This section is required and the request will be denied if not completed.**
4. Purpose of Release of Information: **This section is required and the request will be denied if not completed.** Most of the time we will be requesting information from other providers for the purpose of "sharing with other health care providers as needed" (this is continuity of care or treatment). If the purpose of the release is different from the options provided in the check boxes, please check the box marked "Other" and be very specific.
5. The signed authorization is valid for 90 days or the patient may enter a shorter or longer period of time if they choose, or an event, such as "on my discharge from Alaska Psychiatric Institute." If not a long-term patient, please use 90 days. If the patient chooses the 90 days, please circle "90 days." **This section is required and the request will be denied if not completed.**
6. The individual whose PHI is being released or requested should sign and date the form. If the individual is a minor, or is otherwise unable to sign the form, the individual's authorized representative, should sign and date it. If an authorized representative signs the form, the representative's "legal authority" or "Relationship to Patient" must be indicated. Legal authority includes but is not limited to a parent who signs the form for a minor child or an individual who is a "court appointed legal guardian" over the affairs of the individual whose PHI is being released or requested.
7. This form must be retained in the medical record and a copy should be provided to the client if requested.

QUESTIONS?

Contact the API Privacy Official at (907) 269-7132 with any concerns regarding information privacy, security or access rights.

**REVOCATION SECTION **

I do hereby request that this authorization to disclose the health information of: _____
(Printed Name of Client)

described on the reverse side of this form, be rescinded, effective _____. *I understand that any*
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
Signature of Client or Personal Representative (Or Witness if signature is by mark) | Date

_____ _____
Printed Name of Personal Representative or Witness | Description of Personal Representative's Authority

_____
Signature of Staff

Patient Identification