



**HEALTH INFORMATION MANAGEMENT
AUTHORIZATION TO DISCLOSE BEHAVIORAL HEALTH
PROTECTED HEALTH INFORMATION**

This form is for release of information requests to third parties. Please allow up to 30 days for SEARHC to process your request. Incomplete forms will be returned. There may be a fee associated with processing the request. Staff will inform you if the fee applies.

Printed Name of Patient:	Previous Names (if applicable):
Date of Birth (MM/DD/YYYY):	Daytime Telephone Number:

I REQUEST THE FOLLOWING (CHECK ONE):

Disclose information to and obtain information from (list below)

ONLY obtain information from (initial if limiting information direction): _____

ONLY disclose information to (initial if limiting information direction): _____

INFORMATION TO BE RELEASED FROM:	SEND INFORMATION TO:
Provider Name/Organization:	Name of Person/Facility/Organization:
Address:	Address:
Contact Number:	Contact Number:
Fax Number:	Fax Number:

Format in which you would like the recipient to receive your records: ___ Mail ___ Fax ___ Pick Up ___ Verbal ___ Encrypted email ___ Unencrypted email (there is a risk that your records may be intercepted or viewed if sent unencrypted.) Email address: _____

REQUIRED INFORMATION	
PURPOSE OF DISCLOSURE:	
___ Completing Assessments and aiding in current treatment	___ Providing effective multidisciplinary treatment of individual
___ Transfer of Care	___ Disability
___ Attorney	___ School
___ Law Enforcement	___ Insurance
___ Specialist	___ Other: _____
INFORMATION TO BE DISCLOSED:	
___ Behavioral Health records from the last two years	___ Complete Behavioral Health Designated Record Set
Date(s) of Service: ___/___/___ through ___/___/___	
___ Attendance/Compliance	___ Medication/Dosage
___ Discharge summary	___ Progress notes
___ Referral Note	___ Recommendations
___ Trauma History	___ Billing
___ Written & Telephone Case Communications	___ Accounting of disclosures
___ Interdisciplinary Team Communications	___ Appointment reminders
___ Other: _____	

Disclosures Requiring Special Consent:

If your records contain any of the information listed below, please initial next to that information to indicate that we are allowed to release these type of records:

____ HIV/AIDS Virus ____ Mental Health/Psychiatric Disorders
____ Sexually Transmitted Diseases ____ Substance Use/Treatment

I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.

The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a client in an alcohol or other drug program from re-disclosure.

This form may be revoked at any time by submitting a written request to the address below, provided the information has not already been disclosed. This authorization expires 1-year from date of signing unless an alternate expiration date or event is indicated (not to exceed one-year).

Alternate expiration date/event: _____

We will not condition or deny treatment on completion of this authorization. Please be aware that once we disclose this information, the information is subject to re-disclosure and may no longer be protected by HIPAA.

I have read and understand this form and authorize the information to be released as indicated.

Signature of patient or personal representative* Relationship to patient Date

ID # _____

**legal documentation may be required to confirm the authority or the personal representative.*

SEARHC HIM DEPARTMENT
3100 Channel Dr., Suite 300
Juneau, AK 99801
P: 907-463-6630 F: 907-463-4012

SEARHC Wrangell Behavioral Health
PO Box 1231
Wrangell, AK 99929
P: 907-874-5000 F: 907-874-2576

For Facility Use:

Date Received:	Date Released:	MRN #:	Acct #:	ROI #:	Released by:
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