SEARHC
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

HEALTH INFORMATION MANAGEMENT
AUTHORIZATION TO DISCLOSE 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:

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

____ Transfer of Care ____ Disability ____ Law Enforcement ____ Specialist
____ Attorney ____ School ____ Insurance ____ Other: _______________

INFORMATION TO BE DISCLOSED:

____ Medical records from the last two years ____ Complete Designated Record Set
Date(s) of Service: ____/____/____ through ____/____/____
____ Health Summary ____ Billing records ____ Emergency room records
____ Discharge summary ____ Physician progress notes ____ Nursing notes
____ Laboratory/pathology reports ____ Radiology reports ____ Radiology images
____ Medication list ____ Immunization record ____ Accounting of disclosures
____ Dental chart note ____ Dental Pano X-ray ____ Dental X-ray
____ 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

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 90-days 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

For Facility Use:

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