

**BARTLETT REGIONAL HOSPITAL**

3260 Hospital Drive, Juneau, Alaska 99801 Telephone (907) 796-8900  
Fax to: Health Information Management (907) 796-8468 / X-ray (907) 796-8467 / Lab (907) 796-8466

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address: \_\_\_\_\_ City / State / Zip: \_\_\_\_\_

**INFORMATION TO BE RELEASED FROM BRH / RRC / BOPS**

I hereby authorize (Name of Organization): \_\_\_\_\_ to release the following medical information contained in the patient's medical record. I understand that this authorization is voluntary. **PROHIBITION ON REDISCLOSURE:** This information has been disclosed to you from records whose confidentiality is protected by Federal Regulation (42 CFR Part 2) prohibiting you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is **NOT** sufficient for this purpose. Federal regulation state that any person who violates any provision of this law shall be fined not more than \$500, in case of first offense and not more than \$5000 in the case of each subsequent offense.

**INFORMATION TO BE DISCLOSED TO OR FROM, AND USED BY:**

Name of Facility/ Organization / Individual: \_\_\_\_\_  
Address: \_\_\_\_\_  
City / State / Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_ FAX: \_\_\_\_\_

**IDENTIFICATION VERIFIED BY**

\_\_\_\_\_  
(INITIALS)

**TYPE OF INFORMATION TO BE RELEASED**

- Purpose or need for information being requested:  
 \_\_\_\_\_ Further Medical Treatment    \_\_\_\_\_ Legal Proceedings    \_\_\_\_\_ Insurance Claim  
 \_\_\_\_\_ Other (specify): \_\_\_\_\_
- Dates of treatment: From \_\_\_\_\_ To \_\_\_\_\_
- Amount of Information to be used or disclosed
 

_____ Consultation	_____ History & Physical	_____ Lab Reports
_____ Physical Therapy Notes	_____ Discharge Summary	_____ Operative Report
_____ Progress Note	_____ EKG	_____ Pathology Reports/ Slides
_____ Psychiatric Evaluation	_____ ER Report	_____ X-Ray Films / X-Ray Reports
_____ Other _____	_____ Entire Record	

If the information to be released pertains to alcohol or drug abuse, I understand the confidentiality of the information is protected by federal law (42 CFR, Part 2). Furthermore, I understand that my records may contain information regarding the diagnosis of HIV, AIDS, other sexually transmitted disease, drug abuse, alcohol use, mental illness or psychiatric treatment.

**EXPIRATION AND REVOCATION**

- Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_
- If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signing.
- I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must submit a written revocation to the BRH Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

**I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment at BRH.**

**PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Signature of Patient or Legally Responsible Party	Relationship to Patient	Date
Witness	Date	Released By