

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): Rainforest Recovery Center 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/Chemical Dependency Treatment** _____ Legal Proceedings _____ Insurance Claim
_____ **Other (specify): Compliance with treatment recommendations**

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: Pertinent to chemical dependency treatment** _____ 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: **Criminal Justice Case Concluded.**

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