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