Rainforest Recovery Center

3250 Hospital Drive, Juneau, Alaska 99801 Telephone (907) 796-8690 Fax (907) 586-5605

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Patient Name:____ Birth Date:______________ Medical Record # (if known)_______________

Address: ____ City / State/ Zip: ____________________________

I Hereby Authorize Rainforest Recovery Center to Release Information TO:

Name of Facility/ Organization / Individual: ____

Address: ____

City / State / Zip: ______________________________ Phone Number: _______________ FAX: ________________

I Hereby Authorize Rainforest Recovery Center to REQUEST Information FROM:

Name of Facility/ Organization / Individual: ____

Address: ____

City / State / Zip: ______________________________ Phone Number: _______________ FAX: ________________

- ❑ Dates of treatment: From______________________ To________________________________
- ❑ Purpose or need for information being requested:
  Further Treatment ______ Legal Proceedings ______ Insurance Claim ______ Other (specify): _________________
- ❑ Type of Information to be used or disclosed

_______Consultation _______History & Physical _______Lab Reports ______ ER Report
_______Discharge Summary _______Progress Notes ______Medication List _______Other: ______________________________

I authorize the release of information relating to:

_______ Substance Use Disorder Information ________ Psychiatric Evaluation / Treatment

This information may be transmitted via (patient initial each approved means) ___Fax ____ Verbal ____ Electronically ___Hard Copy

This Authorization 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 may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment at RRC.I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.

The following Prohibition on Re-disclosure will accompany all information released pursuant to this release: “The confidentiality of the records from which this information has been disclosed is protected under Federal law. Federal regulations (42 CFR, Part 2) prohibits recipients of the information from making any further disclosure without the specific written consent of the person to whom it pertains or other permitted by the regulations. I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, RRC their employees and physician(s) cannot prevent re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

I understand that my alcohol and / or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Consumer Records 42 CFR, Part 2 and 45 CFR, and HIPAA and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent through verbal communication or in writing at any time, except to the extent that action has been take in reliance on it. Submit written revocation to the RRC HIM Department.

I further acknowledge that the information to be released has been explained to me and certify that this consent is being given of my own free will.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

___________________________________ _ ______________________ ____________
Signature of Patient or Legally Responsible Party Relationship to Patient Date

_____________________________________ (Witness) Date_______________________