# 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

## AUTHORIZATION FOR RELEASE OF INFORMATION

**PATIENT INFORMATION**

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

Address: __________________________________________ City / State/ Zip: ____________________________

**I Hereby Authorize Bartlett Regional Hospital to Release Information TO:**

Name of Facility/ Organization / Individual: ____________________________________________________________

Address: __________________________________________________________________________________________

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

**I Hereby Authorize Bartlett Regional Hospital 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
_______Physical Rehab Notes _______Discharge Summary _______Operative Report _______EKG Report
_______Pathology Reports _______X-Ray Reports _______X-Ray Films
_______Medication List _______ER Report _______Verbal Exchange
_______Other (be specific- ALL is not acceptable): ____________________________

**I authorize the release of information relating to:**

_______ Substance Use Disorder Information ________ Psychiatric Evaluation / Treatment

**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 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 HIM 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 refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment at BRH.
** 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.
** I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, BRH 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 42 CFR, Part 2 and 45 CFR, parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

**PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

__________________________________ ________________________ ____________

Signature of Patient or Legally Responsible Party   Relationship to Patient   Date

**FOR OFFICE USE ONLY**

ID Verified & Medical Records Released By: ___________________________ Date: ___________________

MR #: _________________________ Date Records Mailed/ Faxed/ Picked Up: ________________ Amount Charged: ________________

Revised 2/2017