Alaska Department of Health
Division of Public Assistance

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name: _____

SSN: _____ Case # or Client ID: _____ Date of Birth: _____

Other Names Under Which Records Might Be Filed: _____

Organization Releasing Information: _____

Organization Receiving Information: **Division of Public Assistance**

_____

Description of Information To Be Released: *(If substance abuse information is to be then this information must be included in the description)*

All medical records supporting disability or incapacity due to mental illness, physical illness, and/or substance abuse.

The purpose of the release of this information is: At the request of the individual

I hereby authorize the use or disclosure of my health care information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section on the back of this release, or by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires one year from the date of signature.

_____ _____
Signature of Client or Personal Representative (Or Witness if signature is by mark) | Date

_____ _____
Printed Name of Personal Representative or Witness | Description of Personal Representative's Authority

NOTE: This authorization was revoked on: _____ *(see reverse for the revocation)*
Date

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

IMPORTANT INFORMATION FOR COMPLETING THIS FORM

INSTRUCTIONS:

1. Enter the Name, SSN, Case # or Client ID, and Date of Birth of the individual whose Protected Health Information (PHI) is being released or requested.

2. Organization Releasing or Receiving Information: Enter "DOH, Division of Public Assistance or its Agents" on either the Releasing line or Receiving line depending on whether the Division or Agent expects to receive information from a health care provider or is releasing information to an individual or organization outside of DOH.

3. Description of Information to be Released: Include specific description of information that is being requested or released. For example, *"Medical and mental health records"*. If alcohol or other substance abuse information is being released or requested, this must be explicitly stated in the description. For example, *"Medical and mental health records, including alcohol or substance abuse records".*

4. The signed authorization is valid for one year. A new authorization must be obtained if there is a lapse in coverage.

5. The individual whose Protected Health Information (PHI) is being released or requested should sign and date the form. If the individual is a minor, or is otherwise unable to sign the form, the individual's authorized representative or witness should sign and date it. If an authorized representative signs the form, the representative's "legal authority" to act on the part of the individual must be indicated. Legal authority includes but is not limited to a parent who signs the form for a minor child or an individual who has power of attorney over the affairs of the individual whose PHI is being released or requested.

6. This form must be retained in the client case file and a copy should be provided to the client at the time of service.

QUESTIONS?

Contact the DPA Privacy Official at (907) 465-3347 or the DOH Privacy Official at (907) 465-4734 with any concerns regarding information privacy, security or access rights.

REVOCATION SECTION

The revocation section should only be completed IF the client wishes to revoke authorization. ***The revocation section should NOT be completed when the authorization is signed initially.***

I do hereby request that this authorization to release the information of: _____
(Printed Name of Client)

described on the reverse side of this form, be rescinded, effective _____. I understand that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
Signature of Client or Personal Representative (Or Witness if signature is by mark) | Date

_____ _____
Printed Name of Personal Representative or Witness | Description of Personal Representative's Authority

_____
Signature of Staff