State of Alaska
Department of Health and Social Services

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
For Enrollment and Eligibility Uses For Disability Determination

Name: _____

SSN: _____ Record # or Other ID: _____ Date of Birth: _____

Complete this box for each Provider

Provider/Organization Releasing Information: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

I hereby authorize the above named health care provider or organization to release to the State of Alaska Department of Health & Social Services and the Department of Labor's Disability Determination Service medical records or other information regarding treatment, hospitalization and/or outpatient care (including drug or alcohol treatment or psychological and psychiatric impairment information that do not include psychotherapy notes). I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand the requested information shall be used solely in the decision of a claim for disability.

I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing or by signing the organization's written revocation form, but if I do, it won't have any effect 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 required to abide by federal privacy regulations, the released information may no longer be protected. 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 Applicant/Recipient or Authorized Representative (Or Witness if signature is by mark) Date

_____ _____
Printed Name of Applicant/Recipient or Authorized Representative (Or Witness if signature is by mark) Description of Authorized Representative's Authority

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 the recipient 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.

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HIPAA Compliant **A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL**

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