State of Alaska

Department of Health and Social Services

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(For Enrollment and Eligibility Uses)

I hereby authorize the release of medical or mental health records, health care billing or payment records, or other information regarding treatment, hospitalization and/or outpatient care requested by the Department of Health & Social Services or its agents. The information released will only be used for the administration of Department of Health & Social Services programs.

Persons or organizations that the Department of Health & Social Services *may* contact include: Department of Law, Department of Labor, Department of Revenue, Bureau of Citizenship and Immigration, Social Security Administration, Department of Health & Social Services contractors and grantees, health care providers, native corporations, Indian Health Services, school authorities, health plans and health insurance agencies, and other local, state or federal agencies as needed to determine eligibility or continued enrollment in services.

I understand that this authorization is voluntary. I understand that the Department of Health & Social Services may condition payment, enrollment in a health plan and/or eligibility for benefits for my dependents or me on whether I provide this authorization. I understand that this authorization will be in effect and may not be revoked while my dependents or I am an applicant or recipient of services from the Department of Health & Social Services. I understand that this authorization remains valid for payment or operational purposes for medical benefits that my dependents or I received, while eligible for Department of Health & Social Service programs even after my dependents or I am no longer eligible. I understand that I may request a copy of this signed authorization.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

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Signature of Applicant/Recipient or Authorized Representative
(Or Witness if signature is by mark)

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Date

____
Printed Name of Applicant/Recipient, Authorized Representative
(Or Witness if signature is by mark)

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Signature of Other Adult Household Member

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Description of Authorized Representative's Authority

____
Printed Name of Other Adult Household Member

____
Social Security Number of Applicant/Recipient

____
Social Security Number of Other Adult Household Member

____
Address of Applicant/Recipient or Authorized Representative

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Phone Number of Applicant/Recipient or Authorized Representative