Yukon-Kuskokwim
HEALTH CORPORATION
P.O. Box 287 • Bethel, Alaska 99559 • 907-543-6000

Release of Patient Health Information

NOTICE TO THE INDIVIDUAL: When authorizing the disclosure (release) of health information, you must be advised of certain rights.

You have the right to:

- Refuse to sign this authorization form. By refusing to sign, it will not affect your treatment, payment, enrollment or eligibility for benefits with the facility;
- Inspect and receive a copy of this authorization form upon your request;
- Receive this authorization in written, plain language. If you do not clearly understand what is being described or what is being requested, contact someone and request that additional instruction be provided before signing this form;
- Revoke this authorization at any time by notifying the authorized entity (who is going to be releasing the information. The revocation may not be valid if the information has already been disclosed (release) before the request for revocation form was received.

Patient's Name: _____ _____ _____ Phone/Contact# _____
First *Middle* *Last*

Address: _____ _____ _____ _____
Mailing or Physical Address *City* *State* *Zip Code*

Disclose (Release) Information From:

Organization: _____

Name/Job Title: _____

Address: _____

City / State / Zip _____

Ph#: _____ Fax#: _____

Email: _____

Disclose (Release) Information To:

Organization: _____

Name/Job Title: _____

Address: _____

City / State / Zip _____

Ph#: _____ Fax#: _____

Email: _____

PURPOSE OF DISCLOSURE (Release): _____

TYPE OF INFORMATION TO BE DISCLOSED: (checkmark each category of information you are authorizing to be disclosed.)

☐ Medical Information:	This authorizes the disclosure of all medical information within the "Designated Medical Record". (This information usually does not include: Psychotherapy Notes or information related to Alcohol & Drug or Mental Health programs, Sexual Assaults, and other types of records that may be further protected by law.	ONCE THE HEALTH INFORMATION HAS BEEN DISCLOSED, PRIVACY LAWS MAY NO LONGER PROTECT IT FROM FURTHER DISCLOSURE. THE PERSON OR ORGANIZATION RECEIVING THE INFORMATION MAY BE AUTHORIZED TO RE-DISCLOSE WITHOUT PATIENT AUTHORIZATION
☐ Sensitive Information:	This authorizes the disclosure of additional medical information which may not be in the "Designated Medical Record, such as: HIV/AIDS, STD's, Sexual Assaults, etc.	
☐ Mental Health/Alcohol:	This authorizes the disclosure of all information contained in any record(s) related to Behavioral Health or Alcohol & Drug program services. (Requests may take longer to complete.) Information within these programs are only permitted to be disclosed in accordance with accordance with 42 CFR, Part 2 regulations.	THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CFR, PART 2). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR, PART 2. THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.
☐ Psychotherapy Notes:	These "notes" are not typically kept in any medical record. Any request for such "notes" must be approved by the Provider or as authorized through a court-order.	

This authorization is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2, and the Privacy Act of 1974 (5 U.S.C §552a)

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Date range: The "To" date must be a date and may not exceed the date of signature.

AMOUNT OF INFORMATION TO BE DISCLOSED (RELEASED): (Check **ONLY** one)
(I understand reasonable, cost-based fees may be charged for copies)

☐ **Complete Record**: (Select one): I authorize the disclosure of all information from:

☐ Entire Record ☐ Between the following dates: From: _____ To: _____

☐ **Summary**: (Select one): I request that treatment/service information be received in a summary.

☐ Electronic summary ☐ Provider written summary
(Additional charges may apply for obtaining a provider's written summary)

☐ **Incident Specific**: I authorize the disclosure of all information that may be related to the incident described below. The exact/approximate date range is provided to assist in locating this specific incident.

Describe incident: _____ From: _____ To: _____

☐ **Specific Dept/Program**: I authorize the disclosure of information only from the department/program listed below and for information between the date range provided.

Dept. Name: _____ From: _____ To: _____

DURATION OF AUTHORIZATION: (Check **ONLY** one)

☐ This Written Authorization shall expire (end) immediately after the information requested has been disclosed (released).

☐ This Written Authorization shall remain valid only during the dates listed*: From: _____ To: _____

☐ This Written Authorization shall remain valid until an ascertainable event has been met:

Describe Ascertainable Event: _____

* If this option was selected, must complete this section:

I hereby (**Check one**) ☐ authorize ☐ deny the authorized recipient to receive any new or additional information that may be created or gathered during the dates listed above or until the ascertainable event has occurred upon request.

DISCLOSURE OF INFORMATION MAY BE DONE BY: I am authorizing the information listed above to be disclosed (released):
(Check all that you are authorizing)

☐ Communications may be done: ☐ In-person ☐ Phone/Cell (not text) ☐ Letter

☐ Written documentation may be: ☐ Picked up ☐ Facsimile (Fax) ☐ Mail ☐ Electronic Mail (Email)

☐ Copied to: ☐ CD/DVD ☐ Memory Card/Stick

☐ Other: (specify) _____

Important! Information that is sent or communicated by phone/cell, facsimile (fax), mail, or electronic mail has the possibility of being intercepted and received by unauthorized individuals. My signature below indicates that I understand this and hereby authorize my information be sent to the intended recipient in the manner authorized on this form.

I understand the rights as described in the notice above and hereby authorize the use and/or disclosure (release) of the information listed above as it pertains to any past, present or future physical health or condition of the individual (patient) listed above.

_____ _____ _____
Patient Signature *Date/Time* *Patient's Date of Birth*

_____ _____ _____
Signature of Parent/Legal Rep. *Date/Time* *Relationship to Patient*

_____
Print Name of Parent/Legal Rep.

This authorization is valid only for the information identified above and to be released only for the purpose stated above and may not be used by the recipient for any other purpose. An expired, deficient, or falsified authorization of disclosure is prohibited.