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| **AUTHORIZATION FOR RELEASE OF CLIENT RECORDS** |
| Client Name:  | Other Names Used: |
| DOB:  | Last four digits of SS#:  | Chart #: | Name of Parent/Legal Guardian:  |
|  |
| **Client Information requested for release:**  | **Purpose of the information:**  |
| 🞏 Continuation of Care🞏 Legal🞏 Insurance | 🞏 Personal at request of patient🞏 Other:  |
| **Dates of Records requested**  | From:  | End:  |
|  |
| Please initial if you also want the following information released: This information is protected by federal law (CFR 42 part 2) |
| Substance Abuse Information  |  | HIV / AIDS Information  |  | Mental Health Information  |  |  |
|  |
| 🞏 **RECORDS IN:** I AUTHORIZE THE FOLLOWING ORGANIZATION TO RELEASE RECORDS TO MOA DHHS: |
| Organization releasing records to MOA DHHS:  |
| Release Client Records to: 🞏 Disease Prevention & Control Clinic 🞏 Reproductive Health Clinic 🞏 Immunizations Clinic |
| Fax to: (907) 249-7992 | OR  | Mail to: Municipality of Anchorage, DHHS Medical Records PO Box 196650, Anchorage, AK 99519-6650 | Attention: |
| ⭬ OR⭪ |
| 🞏 **RECORDS OUT:** I AUTHORIZE MOA DHHS TO RELASE RECORDS TO THE FOLLOWING PERSON/ORGANIZATION: |
| Name / Organization receiving records from MOA DHHS:  | Mailing Address: |
| Phone #:  | Fax #: | Attention: |
| I hereby authorize the use and disclosure of my health information as described above. This authorization is voluntary and I can revoke this release at any time by notifying DHHS in writing. I also understand that information already released does not apply. I further acknowledge that the information to be released may include information that is protected by Federal Law and that the recipient must continue to keep this information confidential. |
| **This Authorization expires *one year* from the date of signature, OR**  |  | **date specified (less than one year)** |
|  |  |  |
| **Signature of Client / Guardian or Representative**  |  | **Date** |
|  |  |  |
| **Print Client / Guardian or Representative Name**  |  | **Description of Representative’s Authority**  |
|  |  |  |
| **Revocation Section**  |
| I hereby request that this authorization to release the information of:  |  | (printed name of client) |
| described on the form above, be revoked, effective (Date) |  |  |  |
|  |  |  |
| **Signature of Client / Guardian or Representative**  |  | **Date** |
|  |  |  |
| **Print Client / Guardian or Representative Name**  |  | **Description of Representative’s Authority**  |
| **Signature of Staff:**  |  |  |  |