Municipality of Anchorage, Anchorage Health Department
Direct Services Division, Clinical Services
PO Box 196650 Anchorage, AK 99519-6650
Phone: (907) 343-4799, Fax: (907) 249-7992
Email: AHDCommunityHealthNursing@anchorageak.gov

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 (Select all that apply):	**Purpose of the information:**	
☐ Immunization Record ☐ Tuberculosis Labs/Record ☐ Reproductive Health Labs/Record ☐ Last Pap Result ☐ Other, please specify:	☐ 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** the MOA AHD:

Organization releasing records to MOA AHD:

Release Client Records to: ☐ Disease Prevention & Control Clinic ☐ Reproductive Health Clinic ☐ Immunizations Clinic

Fax to: (907) 249-7992
OR Mail to: Municipality of Anchorage, AHD Medical Records, PO Box 196650, Anchorage, AK 99519-6650. Email: AHDCommunityHealthNursing@anchorageak.gov. Attention:_____

⇢ OR ⇠

☐ RECORDS OUT: I authorize MOA to **release** records to the following person(s)/organization:

Name / Organization receiving records from MOA AHD:		Mailing Address and/or Email 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 AHD 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. I understand the consequences if I refuse l to sign the authorization when, in accordance with this policy, AHD can condition treatment, enrollment in the health plan, or eligibility for benefits; and the potential for information disclosed pursuant to the authorization be subject to re-disclosure by the recipient and no longer be protected by HIPAA Privacy standards.

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**

RIGHT TO REVOKE

I hereby request that this authorization to release the information of (print client name):_____ 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: _____