



Municipality of Anchorage,
 Department of Health and Human Services
 Direct Services Division
 Clinical Services
 PO Box 196650 Anchorage, AK 99519-6650
 Medical Records Phone: (907)343-4792



AUTHORIZATION FOR RELEASE OF CLIENT RECORDS

Release Client Record to DHHS	Client Name:		Other Names Used:	
	DOB:	SS#:	Chart#	
	Organization Releasing Records:			
	Release client record to:			
	<input type="checkbox"/> Disease Prevention & Control Attention :		<input type="checkbox"/> Reproductive Health Center Attention :	
	Fax to: (907) 249-7992 or			
	Mail to: Municipality of Anchorage, DHHS Medical Records P.O. Box 196650 Anchorage, AK 99519-6650			
Client information requested for release:		Purpose of the information:		
		<input type="checkbox"/> Continuation of Care <input type="checkbox"/> Personal at the Request of Patient <input type="checkbox"/> Legal <input type="checkbox"/> Other <input type="checkbox"/> Insurance		

Client requests record to be release to:	Client Name:		DOB:	Chart #	
	Send to:				
	Fax #:		Attention:		
	Mailing Address:				
	Client information requested for release:		Purpose of the information:		
			<input type="checkbox"/> Continuation of Care <input type="checkbox"/> Personal at the Request of Patient <input type="checkbox"/> Legal <input type="checkbox"/> Other <input type="checkbox"/> Insurance		
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 <input type="checkbox"/>					

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 of this information must continue to keep this information confidential.

This Authorization expires *One year* from the date of signature.

 Signature of Client / Guardian or Representative

 Date

 Print Guardian or Representative Name

 Description of Representative's Authority

NOTE: This authorization was revoked on: _____ **(see reverse)**



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Revocation Section

I hereby request that this authorization to release the information of: _____
 (Printed Name of Client)

described on the reverse side of this form, be revoked, effective (Date) _____.

I understand that any action taken on this authorization prior to the date revoked is legal and binding.

 Signature of Client or Personal Representative

 Date

 Printed Name of Personal Representative or Witness

 Description of Personal Representative's Authority

 Signature of Staff