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: ☐ **Disease Prevention & Control** **Attention :**		☐ **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: ☐ Continuation of Care ☐ Personal at the Request of Patient ☐ Legal ☐ Other ☐ 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: ☐ Continuation of Care ☐ Personal at the Request of Patient ☐ Legal ☐ Other ☐ 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		☐

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NOTE: This authorization was revoked on: _____ **(see reverse)**

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

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