SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

HEALTH INFORMATION MANAGEMENT
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH

This form is for release of information requests to third parties. Please allow up to 30 days for SEARHC to process your request. Incomplete forms will be returned. There may be a fee associated with processing the request. Staff will inform you if the fee applies.

Printed Name of Patient:	Previous Names (if applicable):
Date of Birth (MM/DD/YYYY):	Daytime Telephone Number:

INFORMATION TO BE RELEASED FROM:	**SEND INFORMATION TO:**
Provider Name/Organization: **SEARHC**	Name of Person/Facility/Organization: **Central Council Tlingit & Haida Indian Tribes of Alaska - Head Start**
Address: 3100 Channel Drive Ste. 300 Juneau, AK 99801	**Address:** P.O. Box 25500 Juneau, AK 99802
Contact Number: 907.463.6630	**Contact Number:** 1.800.344.1432/x7127
Fax Number: 907.463.4012	**Fax Number:** 1.877.389.7796

Format in which you would like the recipient to receive your records: ____Mail __X__Fax ___Pick Up ____Verbal ____Encrypted Email ____Unencrypted email (there is a risk that your records may be intercepted or viewed if sent unencrypted.) Email address: _____

REQUIRED INFORMATION

PURPOSE OF DISCLOSURE:

____Transfer of Care ____Disability ____Law Enforcement ____Specialist
____Attorney __X__Head Start School ____Insurance ____Other: _____

INFORMATION TO BE DISCLOSED:

____Medical records from the last two years ____Complete Designated Record Set
Date(s) of Service: ____/____/____through ____/____/____

____Health Summary ____Billing records ____Emergency room records
____Discharge summary ____Physician progress notes ____Nursing notes
____Laboratory/pathology reports ____Radiology reports ____Radiology images
____Medication list __X__Immunization record ____Accounting of disclosures
____Dental chart note ____Dental Pano X-ray ____Dental X-ray

__X__Other: ***Head Start Physical Exam Form*** (*Including: Grow measurement, Blood Pressure, Vision, Hearing, TB, Hemoglobin/Hematocrit, Physical/Developmental Assessment, allergies and chronic illness*), & **Head Start Dental Exam Form** (*Including: Procedures Performed, Caries Risk Status, Current Oral Health Status, Recommendations, & Treatment Plan*)

Disclosures Requiring Special Consent:
If your records contain any of the information listed below, please initial next to that information to indicate that we are allowed to release these type of records:

____HIV/AIDS Virus ____Mental Health/Psychiatric Disorders ____Sexually Transmitted Diseases
____Substance Use/Treatment

This form may be revoked at any time by submitting a written request to the address below, provided the information has not already been disclosed. This authorization expires 90-days from date of signing unless an alternate expiration date or event is indicated (not to exceed one-year.)

Alternate expiration date/event: **1 Year from date of signature**

We will not condition or deny treatment on completion of this authorization. Please be aware that once we disclose this information, the information is subject to re-disclosure and may no longer be protected by HIPAA.

I have read and understand this form and authorize the information to be released as indicated.

Signature of Patient or Personal Representative* **Relationship to Patient** **Date**

ID #

**legal documentation may be required to confirm the authority or the personal representative*.

SEARHC HIM DEPARTMENT
3100 Channel Dr., Suite 300
Juneau, AK 99801
P: 907.463.6630 F: 907.463.4012

For Facility Use:

Date Received:	Date Released:	MRN #:	Acct #:	ROI #:	Released by: