Advanced Authorization for Release of Information

4951 Business Park Boulevard, Anchorage, AK 99503
www.ANHC.org, Phone 907-743-7200, Fax 907-743-7255

PLEASE READ: You should only fill out this form if you want to have medical or dental information sent to Anchorage Neighborhood Health Center (ANHC), or if you want information from your ANHC records provided to another source.

Patient Name:_____ DOB:____-____-____

Last Four Digits of SS#: _____ Phone:_____ Evening Phone: _____

Address: _____ City:_____ State:_____ Zip: _____

As the Patient, Parent/Guardian, or Representative (*legal documents required*), I hereby authorize Anchorage Neighborhood Health Center to:

❒ **Obtain Information from: -OR- ❒ Release Information to:**
PLEASE CHOOSE ONLY ONE PER FORM

Name: _____

Address:_____ City:_____ State:_____ Zip: _____

Phone:_____ Fax: _____

Please check any types of information to be released:

- ❒ History and Physical
- ❒ Progress Notes
- ❒ Lab Reports
- ❒ X-Ray Reports
- ❒ Immunization Records
- ❒ Medication List
- ❒ Other:_____

Date range of records to be released [unless specified in notes]**:**

- ❒ Records from the past 12 months
- ❒ Records from most recent 3 visits

Notes: _____

Please provide additional authorization for the specific release of any information relating to these topics:

[check any topics that you authorize release of information for]

- ❒ Substance Use Disorder
- ❒ Mental Health
- ❒ HIV-Related Information

X _____ _____
Signature of Patient or Representative — Date

PURPOSE OF DISCLOSURE: I understand that authorizing the disclosure of this health information is voluntary. I understand that this authorization will expire one (1) year after I have signed this form. I understand that I may revoke this authorization at any time by notifying Anchorage Neighborhood Health Center in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. By authorizing this release of information, my treatment, health care, and payment for my heath care will not be affected if I do not sign this form. I understand that I will get a copy of this form after I sign it. In order to offset the cost of maintaining and producing copies of the medical record, ANHC does charge for copies. There is no charge for medical records if copies are sent to other health care facilities for ongoing care or follow-up treatment. *Note: Per HIPAA guidelines, patients are NOT required to give a purpose for their use of health information Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.524.

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from patient records whose confidentiality is protected by Federal Regulations (42 CFR Part 2) prohibiting you from making any further disclosure of this information except with the specific written consent of the person of to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

_____ _____ **-OR-** _____ _____
Patient Signature — Date — Representative — Date

_____ _____
Print Name — Relationship to Patient

FOR OFFICE USE ONLY Date Request Filled:_____ Filled By: _____

ID VERIFIED BY ANHC EMPLOYEE (Name, List ID Verification Method, and Initial): _____