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 and Haida Indian Tribes of Alaska- Head Start**
Address: 3100 Channel Drive Ste. 300 Juneau, AK 99801	**Address:** 9095 Glacier Hwy Juneau, AK 99801
Contact Number: 907-463-6630	**Contact Number:** 1.800.344.1432/x7153
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: _**WIC *exam and 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*) _____

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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: