ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
Health Information Management
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AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name:		Date of Birth:
Prior Name(s) Used:		Phone #:
Patient's address		
City:	State:	Zip Code:
Email Address:		

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize ANTHC to release my medical records to: ❐ Myself or ❐ Recipient listed below:

Recipient's Name:		Attention To:
Recipient's Address:		
City	State:	Zip Code:
Phone:	Fax:	Email:
Format: ☐ Paper ☐ CD/DVD ☐ Fax ☐ USB ☐ Digital File		Delivery Option: ☐ Pick-up ☐ Mail ☐ Email ☐ Fax

INFORMATION TO BE RELEASED FROM:

I request my protected health information (PHI) be released from:
☐ ANTHC ☐ ANMC ☐ SCF ☐ Clinic Name/THO (Please Specify): ______________________________

INFORMATION TO BE RELEASED: (must complete)

❐ Specific Date(s): ________________ to ______________ ❐ All Dates ❐ Related to Specific Diagnosis __________________________

❐ Emergency Dept. Records	❐ Laboratory Report(s)	❐ Radiology/Imaging Report(s)
❐ History & Physical	❐ Pathology Report(s)	❐ Radiology Film/other Diagnostic Images
❐ Consultation(s)	❐ EKG	❐ Billing/Itemized Bill
❐ Operative/Procedure Report(s)	❐ Sleep Study	❐ Complete Health Record
❐ Discharge Summaries	❐ Immunization Record	❐ Other__________________________

PURPOSE FOR REQUESTING INFORMATION: (must select one)

☐ Personal	☐ State/Federal	☐ Insurance	☐ Legal
☐ Care Coordination/School	☐ Other: __________________________		

EXPIRATION:

This authorization will expire one (1) year from the signature date, unless an alternative expiration date is provided here: ___/___/___
Revocation: An authorization may be revoked at any time by written notice to ANTHC Health Information Management. Revocation is not effective until notice is received and is not effective regarding disclosures made before revocation and where authorization was obtained as a condition of insurance coverage.

By signing this authorization form, I understand that:

- Protected health information may include records relating to mental health care, sexually transmitted diseases, Genetic/Metabolic Testing, HIV/AIDS, and/or treatment of alcohol/drug abuse. I have the right to revoke this authorization at any time.
- I understand that I may request a copy of the signed authorization.
- I understand that I do not have to sign this authorization, that my treatment or payment for services will not be denied if I do not sign this authorization, and that I have a right to inspect and receive a copy the protected health information to be used or disclosed.
- I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements including HIPAA and the Privacy Act of 1974. Alaska Native Tribal Health Consortium, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Patient or Patient Representative Signature (required) ▶	**Date** (required) (mm-dd-yyyy)
Patient or Patient Representative Printed Name (First, Middle, Last)	

Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)
☐ Self ☐ Parent/Guardian ☐ Legally Authorized Representative ☐ Other: ___________________