

South Peninsula Hospital 4300 Bartlett St. Homer, AK 99603 907-235-0232, fax 907-235-0252

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION (PAGE 1 OF 2)

Notice: This re	equest is not valid unles	s all requested informati	on is provided.			
Release From:	□ SOUTH	PENINSULA HOSPITAL	4300 BARTLETT	ST HOMER, AK 99603 235-0232		
OR ANOTHER			Pho	one:		
	Address:					
Release To:		ER PHYSICIAN, ANOTHER REL		one:		
Patient Identifi	cation: Patient Name: _			Date of Birth:		
Address:	Address: Social Security #:					
		Т	elephone(s) #:			
Information To	Be Released (please b	e specific):				
From (date)	To (dat	e)		dditional signature requirements.		
☐ Consultatio		☐ Itemized Bill		PT/OT Therapy Notes		
☐ Discharge \$		☐ Laboratory/Pathology		Speech Therapy		
	Dept Report	☐ Medication List		Transfer Summary		
☐ History & P		☐ Photographs/Videota		* Drug/Alcohol Abuse Notes		
☐ Imaging CD	•	☐ Procedure/Operative		* HIV Related Information		
Imaging Re	ports	Progress Notes		* Psychiatric Reports		
□ Other (spec	cify):					
Receive by: Mail Pick-up Fax: PLEASE CHECK THIS BOX IF YOU WANT YOUR RECORDS PROVIDED ON CD (INSTEAD OF PAPER) Purpose of the Request:						
•	t the request of pt.)	☐ Treatment ☐ Lo	egal 🗖 Insu	rance		
			nd handling. There is NO	e first ten (10) pages, then 50 cents for each page Ofee for purposes of "treatment" or "insurance"		
FOR OFFICE USE	ONLY					
DATE RECEIVED:	DATE CC	MPLETED:#	OF PGS RELEASED:_	COMPLETED BY:		
	ELEASED:					
	METHOD		ID CHECKED	BY:		

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION (PAGE 2 OF 2)

TERMS

I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information.

EXPIRATION & RIGHT TO REVOKE AUTHORIZATION

Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to the Health Information Management Department. Unless revoked earlier, this authorization will expire six months from the date on which it was signed, or upon the following date or event:

RE-DISCLOSURE

I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

DRUG AND ALCOHOL TREATMENT INFORMATION

Federal regulation (42 CFR part 2) prohibits any further disclosure of this information except with specific written consent of the person to whom the information pertains or the parent/legal guardian of a minor child to whom it pertains, unless otherwise permitted by federal law. A general authorization for the release of information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of the law shall be fined not more than \$5,000 in the case of a first offense and not more than \$5,000 in the case of each subsequent offense. (See 42 USC 290dd-3 and 42 USC 290ee-3).

MENTAL ILLNESS

State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or the parent/legal guardian of a minor child to whom it pertains, unless permitted by state law. A general authorization for the release of information is NOT sufficient for this purpose.

SEXUALLY TRANSMITTED DISEASE INFORMATION (Includes HIV / AIDS)

State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or the parent/legal guardian of a minor child to whom it pertains, unless permitted by state law. A general authorization for the release of information is NOT sufficient for this purpose. Any violation of the law is a gross misdemeanor, and the law creates civil remedies for any violations which include a \$1,000 fine for negligent violation, \$2,000 fine for an intentional or reckless violation or actual damages, whichever is greater, and attorney's fees.

CONSENT OF A MINOR

With certain age restrictions, a minor patient's signature is required in order to release information concerning care for:

- 1) Pregnancy termination and sexually transmitted diseases
- 2) Alcoholism or drug abuse
- Mental health conditions

Si	gnature:	Date:			
Pr	int:				
	signed by legal representative, relationship to patient:				
A specific authorization is required to disclose information regarding the following:					
(C	heck box and sign to specify information to be disclosed)	Signature			
	Psychiatric / Mental Health / Mental Health Consults				
	Drug / Alcohol Abuse				
	HIV Lab Test Result				