South Peninsula Hospital

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 request is not valid unless all requested information is provided.

Release From: ❒ **SOUTH PENINSULA HOSPITAL 4300 BARTLETT ST HOMER, AK 99603 235-0232**

OR ANOTHER FACILITY:

Name: _____ Phone: _____

Address: _____

Release To: Name: _____ Phone: _____
(I.E. SELF, ANOTHER PHYSICIAN, ANOTHER RELATIVE)

Address: _____

Patient Identification: Patient Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Telephone(s) #: _____

Information To Be Released (please be specific): _____

From (date) _____ To (date) _____

Please check type of information to be released. Items marked with an * have additional signature requirements.

❒ Consultation Reports	❒ Itemized Bill	❒ PT/OT Therapy Notes
❒ Discharge Summary	❒ Laboratory/Pathology Results	❒ Speech Therapy
❒ Emergency Dept Report	❒ Medication List	❒ Transfer Summary
❒ History & Physical	❒ Photographs/Videotapes/CDs	❒ * Drug/Alcohol Abuse Notes
❒ Imaging CDs	❒ Procedure/Operative Notes	❒ * HIV Related Information
❒ Imaging Reports	❒ Progress Notes	❒ * Psychiatric Reports
❒ Other (specify):		

Receive by: ❒ Mail ❒ Pick-up ❒ Fax: _____ ❒ E-Mail: _____

❒ CD ❒ Portable Media (thumb/flash drive provided by SPH): Preferred Password: _____

Purpose of the Request:

❒ Personal (at the request of pt.) ❒ Treatment ❒ Legal ❒ Insurance ❒ Government
❒ Other (specify): _____

Please note that there is the potential for a copy fee. Our policy states that there will be a charge of $20.00 for the first ten (10) pages, then 50 cents for each page thereafter. There may also be a fee of $10.00 or cost (whichever is higher) for postage and handling. There is NO fee for purposes of "treatment" or "insurance" as stated above under "Purpose of the Request".

FOR OFFICE USE ONLY

DATE RECEIVED: _____ DATE COMPLETED: _____ # OF PGS RELEASED: _____ COMPLETED BY: _____

INFORMATION RELEASED: _____

DATE SENT: _____ 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 $500 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
3) Mental health conditions

Signature: _____ Date: _____

Print: _____

If signed by legal representative, relationship to patient: _____

A specific authorization is required to disclose information regarding the following:

(Check box and sign to specify information to be disclosed) *Signature*

❒ **Psychiatric / Mental Health / Mental Health Consults** _____

❒ **Drug / Alcohol Abuse** _____

❒ **HIV Lab Test Result** _____