Authorization: Release of Health Information

South Peninsula Hospital | 4300 Bartlett St. | Homer, AK 99603

PATIENT IDENTIFICATION:

Name: _____ Date of Birth: _____

Address: _____

Phone(s): _____ Last four (4) digits Social Security Number: _____

RELEASE FROM:

South Peninsula Hospital Facilities:

- ☐ South Peninsula Hospital (SPH)
- ☐ Family Care Clinic
- ☐ General Surgery Clinic
- ☐ Home Health
- ☐ Infusion Clinic
- ☐ Long Term Care Facility
- ☐ Neurology Clinic
- ☐ Sleep Lab/Sleep Clinic
- ☐ Specialty/ Orthopedic Clinic
- ☐ Homer Medical Center (HMC)
- ☐ Serene Waters Mental Health Clinic
- ☐ Seaworthy Functional Medicine
- ☐ Seaside Women's Care (Formerly HMC West-Wing OB/GYN)
- ☐ Renew Plastic Surgery & Dermatology

☐ **Or Another Facility:** _____ Phone: _____ Fax: _____

Address: _____

RELEASE TO:

☐ South Peninsula Hospital (Health Information Management - Phone: 907-235-0232, Fax: 907-235-0252)

☐ Homer Medical Center: (Phone: 907-235-8586, Fax: 907-235-6639)

☐ Name: _____ Phone: _____ Fax: _____

(i.e., Self, or name of Clinic, Hospital, Personal Representative, Physician, Relative, etc.)

Address: _____

INFORMATION TO BE RELEASED:

Please check type of information to be released.

NOTE: Items marked with an asterisk (*) have additional signature requirements. "Special Authorization: Release of Select Health Information" [FORM HW.ROI.004] must be completed for items highlighted in yellow. See next page for additional details.

From (date): _____ To (date): _____

- ☐ ***Complete/Formal Medical Record**
- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ ***Drug/Alcohol Treatment**
- ☐ Emergency Dept Report
- ☐ Encounter/Visit Notes
- ☐ History & Physical
- ☐ Imaging CDs
- ☐ Imaging Reports
- ☐ Itemized Bill
- ☐ Medication List
- ☐ Laboratory/Pathology Results
- ☐ Photographs/Videotapes/CDs
- ☐ Procedure/Operative Notes
- ☐ Progress Notes
- ☐ ***Psychiatric Reports**
- ☐ PT/OT Therapy Notes
- ☐ Sleep Study Interpretation
- ☐ Speech Therapy
- ☐ ***STI Information**
- ☐ Transfer Summary
- ☐ Other: _____

Receive by:

☐ USPS ☐ Pick-up ☐ Fax: _____ ☐ Email: _____

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

Purpose of Request:

☐ Personal (patient request) ☐ Treatment ☐ Legal ☐ Insurance ☐ Government

☐ Other (specify): _____

(continues next page)

South Peninsula Hospital

Patient Label

Authorization: Use & Disclosure of Health Information

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 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 one year** from the date on which it was signed, or on the following date or event: _____,
whichever comes first.

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.

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) Drug or alcohol treatment
3) Mental health conditions

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 treatment patient. Federal regulations state that any person who violates any provision of the law shall be fined in accordance with 42 USC 290dd-3 and 42 USC 290ee-3.

PSYCHIATRIC / MENTAL HEALTH / MENTAL HEALTH CONSULT(S)
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 INFECTIONS 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 includes fines as defined under Alaska Statute 18.15.400(f).

Use of "Special Authorization: Release of Select Health Information" [FORM HW.ROI.004] is mandatory for the release of these categories of medical records.

Patient/Representative Signature: _____ Date: _____ Time: _____

Name Printed: _____

If signed by legal representative, relationship to patient: _____

For Office Use Only

Date Received: _____ Date Completed: _____ # Of Pages Released: _____ Completed By: _____

Information Released: _____

Date Sent: _____ Method: _____ Fax # Sent to: _____ ID Checked By: _____

South Peninsula Hospital

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