

Special Authorization: Release of Select Health Information

A COPY OF THIS FORM MUST BE INCLUDED WITH THE RECORD SET RELEASED.

1. Patient Identification:

Name: _____ Date of Birth: _____

Address: _____

Phone(s): _____ MR#: _____

2. Release From:

- South Peninsula Hospital** (Health Information Management - **Phone:** 907-235-0232, **Fax:** 907-235-0252)
 Serene Waters - **Phone:** 907-235-7202, **Fax:** 907-435-3053

3. Release To: May be disclosed to an entity without the name of a specific person (e.g., Social Security Administration)

Name: _____ Phone: _____

Email: _____ Fax: _____

Address: _____

4. Substance Use Disorder (SUD) Counseling Notes

- A separate consent is required for the use and disclosure of SUD counseling notes. If this checkbox is selected, please skip question number 5 and proceed to question number 6.

5. Information to be Released:

- Psychiatric / Mental Health / Mental Health Consult(s)
 Drug and Alcohol Treatment Information
 Sexually Transmitted Infections Information

6. Please provide an explicit description of the treatment information to be provided. Limit information to only necessary to carry out the stated purpose:

7. Purpose of Release of Information:

- Personal (patient request)
 Continuity of Care or Treatment
 Insurance
 Government
 Legal
 Other: _____

8. Receive by:

- USPS Pick-up
 Fax: _____
 Email: _____
 CD
 Portable Media (thumb/flash drive provided by SPH):
Preferred Password - _____

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 | 4300 Bartlett St. | Homer, AK 99603

Patient Label

Authorization: Use & Disclosure of Select 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.

RE-DISCLOSURE

Information contained in this release is prohibited from redisclosure without further disclosure expressly permitted by written consent to whom it pertains as dictated by the federal confidentiality rules.

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

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:

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 including fines as defined under Alaska Statute 18.15.400(f).

By signing below, I agree that I understand the terms of this authorization.

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

Name Printed: _____

If signed by legal representative, relationship to patient: _____

