## Authorization to Release Healthcare Information

| | |
|---|---|
| ______________________________________ | ________________________ |
| Patient's Name: (Last, First M.) | Patient's Date of Birth |
| ______________________________________ | ________________________ |
| Street Address | Patient Phone Number |
| ______________________________________ | |
| City, State, Zip Code | |

I hereby authorize use or disclosure of protected health information about me as described below:

1. Release: (check one) To or From

   Alaska Psychological Services
   741 Sesame Street, Suite 1B
   Anchorage, AK 99503
   Phone: 907-334-1000 Fax: 907-334-8080

2. Release: (check one) To or From
   Name of Individual or Facility: ________________________________
   Address of Individual or Facility: ________________________________
   ________________________________
   Phone or Fax Number ________________________________

3. Specific Information to be released: (Please indicate dates of services if known.)
   ____________________________________________________________

4. Below is a list of information that requires specific authorization. **<u>Please SIGN accordingly</u>.**
   Alcohol/Substance Abuse: ________________________________________
   HIV/AIDS:________________________________________________
   **Mental Health**: ______________________________________________

This authorization is valid:

- For a period of ________ month(s) from the date of my signature below **OR**
- Until the completion of ______________________________ **OR**
  (Specific event or purpose of release)
- Indefinite

- I understand the information provided under this authorization may include Protected Health Information which could contain diagnosis, treatment information and/or personal background history.
- I understand the information to be disclosed is protected by law and the same information may be re-disclosed by the recipient and may no longer be protected by the same law(s) that applied in the first instance.
- I understand the Authorization is effective until the date or the even indicated above unless I revoke this Authorization before it expires. I understand I may revoke this Authorization at any time during its effective period by requesting such in writing to
  Alaska Psychological Services, 741 Sesame Street, Suite 1B Anchorage AK 99503.

| | | |
|---|---|---|
| ______________________________________ | | ________________ |
| Signature of Patient | | Date of Signature |
| ______________________________________ | ________________ | ________________ |
| Signature of Guardian/Authorized Representative | Relationship to Patient | Date of Signature |