

MAT-SU HEALTH SERVICES, INC.
 1363 W Spruce Ave
 Wasilla, AK 99654
 Phone 907 376-2411 Fax 907 352-3373
Authorization of Release of Records or Information

Name: _____ Birth Date: _____
 (Name of client whose information is released)

I, Client Parent Legal Guardian hereby authorize MAT-SU HEALTH SERVICES, INC.

Disclose information to:	and/or	Obtain information from:
Name: _____		
Address: _____		
Phone: _____		
(Name of agency or individual which information is being disclosed or sought)		

The following *protected health information* from my records (Specify extent or nature of information to be disclosed)

*Initial each that applies:

<input type="checkbox"/>	Discharge and Summary Recommendation
<input type="checkbox"/>	Intake Summary
<input type="checkbox"/>	Other--Specify
<input type="checkbox"/>	Progress Notes: Clinician, Doctor, or Family Support
<input type="checkbox"/>	Psychiatric Evaluation
<input type="checkbox"/>	Social History
<input type="checkbox"/>	Treatment Plans
<input type="checkbox"/>	Verbal information

This information is for the purpose of:

Further Treatment	Insurance	Coordination of Care	Other
Disability Claim	Legal Request	Personal	Other

- I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.
- I understand that the information in my health record may include information relating to behavioral or mental health services and/or treatment for alcohol and drug abuse.

I understand I have the right to receive a copy of this authorization form. I also understand that upon my written request, MSHS must provide me a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes.

Signature of client : _____ Date: _____
 (minor's signature is required)

Parent /guardian: _____ Date: _____

Witness: _____ Date: _____

*This authorization will terminate one year from the date the consent is signed, or unless an earlier date or condition/ event is specified here: _____

SERVICE PROVIDER TO COMPLETE		FOR OFFICE USE ONLY	
<input type="checkbox"/> Send for Records	<input type="checkbox"/> Send Authorization	Date Sent _____	By Whom: _____
<input type="checkbox"/> Release MSHS Records	<input type="checkbox"/> File Authorization	Info Sent _____	

This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. 42 CFR Part 2 prohibits you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is not sufficient for this purpose.

This authorization is revoked: Date _____ Name: _____

HIPAA/Authorization: MHS Applied 7/1/03 **A Faxed copy of this release shall be considered as original**