

MAT-SU HEALTH SERVICES, INC.
 1363 W Spruce Ave
 Wasilla, AK 99654
 Phone 907 376-2411 Fax 907 352-3301
Authorization of Release of Records or Information

Name: _____ Birth Date: _____
 (Name of person whose information is to be released)

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

_____ 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: (Family Care Clinic)

	Discharge Summary
	History and Physical
	Other--Specify
	Progress Notes
	Lab
	Radiology
	Medications
	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: _____

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	
_____ Send for Records	_____ Send Authorization	Date Sent _____	By Whom: _____
_____ Release MSHS Records	_____ 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: _____