NSHC Authorization to Use and Disclose Health Information

(Norton Sound Health Corporation to Release Information to Other Party)

Patient

Patient Name: _____ **(Patient)**

Birth Date: _____ **Ph. #:** _____ **Medical Record #:**_____

Address:_____

From

I authorize Norton Sound Health Corporation (NSHC) to disclose Patient's health information as described below.

To

Health information is to be disclosed to and received and used by:

Kawerak Inc. Vocational Rehabilitation Program

P.O. Box 948 Nome, AK 99762

(name/address of recipient)

Purpose

For the purpose(s) of:

☐ **At my request**

☑ **Other purposes (specify each purpose):** eligibility determination for vocational rehabilitation services

Information to be Disclosed

Description or nature of information to be disclosed and includes information in any medium, including paper, electronic, and verbal information: (check all that apply)

- ☐ Discharge summaries
- ☐ History & physical exams
- ☐ Consultations
- ☐ Operative reports
- ☐ Physician progress notes
- ☐ Nursing notes
- ☐ Medication records
- ☐ Pathology reports
- ☐ Radiology & imaging reports
- ☐ Laboratory reports
- ☐ EKG Reports
- ☐ Emergency Dept. records
- ☐ Billing statements
- ☐ Clinic or office notes

Specially Protected Information about:
(must be checked to be disclosed):

- ☐ Mental health treatment
- ☐ Drug/alcohol abuse diagnosis, treatment, & referral
- ☐ HIV / AIDS Information

- ☐ Records for the following dates or treatment: _____
- ☐ Other information (specify): _____

All health records from NSHC (Minimum Necessary for purposes of disclosure) (Excludes the above Specially Protected Information unless box(es) checked.)

Notices

1. **There is the potential for information disclosed under this authorization to be re-disclosed by the recipient and no longer protected by federal or state privacy laws. But, if the information being disclosed under this authorization includes HIV/AIDS, mental health, and drug/alcohol abuse information, then federal or state law may prevent the recipient from re-disclosing this information.**

2. **I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations, or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.**

3. **I may revoke this authorization at any time by notifying, in writing, the Director of Health Information Management of NSHC; however, any such revocation will not apply to any disclosure or action already undertaken based on this authorization.**

4. **I will receive a copy of this authorization after it is signed. I may inspect or request copies of information disclosed by this authorization.**

Dates

Unless revoked, this authorization is valid for the following time period:

Beginning date: _____ **Ending (expiration) date:**_____

Signature

SIGNATURE: I have read this authorization; I have had an opportunity to ask questions; I understand this authorization; and I willingly am signing this authorization.

_____ _____

Signature of Patient or legal/personal representative **Date**

If not signed by Patient, Authority to sign on behalf of Patient: _____