NSHC/BHS Authorization to Use and Disclose Health Information

Patient

Patient Name: _____ Patient Birth Date: _____/_____/_____ Ph. #: _____/_____/_____

Address: _____ Medical Record #_____

From

I authorize: ☐ ***Norton Sound Health Corporation; or***

☐ ***Other entity (insert entity information below)***

Entity Name: _____ **Address:** _____ **Contact Phone Number:** _____/_____/_____

to disclose Patient's health information as described below. **Fax Number:** _____/_____/_____

To

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

☐ ***Norton Sound Health Corporation; or***

☐ ***Other entity (insert entity information below)***

Entity Name: **Kawerak, Inc. Vocational Rehabilitation Program** **Address:** P.O. Box 948, Nome, AK 99762 **Contact Phone Number:** 907 / 443 / 4364

Fax Number: 465 / 658 / 9241

I authorized, _____, if I'm unable to pick up my medical records (I.D. required from both parties).

Purpose

For the purpose(s) of:

☐ At my request

☐ Other purposes (specify each purpose): This release of information is to determine eligibility 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: _____
(Specify the information you are requesting with the Months, Dates, and or Years)

☐ **ALL MEDICAL RECORDS:** _____
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. 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, but those laws will vary depending on the location and type of records. Information covered by the Federal Regulations Governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) shall not be disclosed without proper consent.
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 NSHC in writing for all records, except that an authorization for records covered by 42 CFR Part 2 (Substance Abuse Treatment information) may be revoked orally by notifying the Director of Behavioral Health Services at 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 (if left blank this authorization will expire 1 year from signature date):

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 am willingly signing this authorization.

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

If not signed by Patient, Authority to sign on behalf of Patient (Specify relationship to the Patient): _____

_____ _____
Printed Name of NSHC /Agency Witness (not required by departments of State of Alaska) **Date**

_____ _____
Signature of NSHC /Agency Witness (not required by departments of State of Alaska) **Date**