Denali Family SERVICES

COA Council on Accreditation Founded 1977

1251 Muldoon Ste. 116 • Anchorage, AK 99504
Phone (907) 274-8281 • Fax (907) 274-4055
www.denalifs.org

Authorization for Release of Information

Patient Info

Name: ____
First Last M.I.

Alias (if applicable): ______________________________ **DOB:** __________
First Last M.I. (MM/DD/YY)

Disclosing Party Information

By filling out the form below, I allow **Denali Family Services** to disclose to and receive information from the following person and/or agency:

All Denali Family Services foster parents & homeworkers that are or may be involved with the individual's care

Information to be Released

Please check or initial the information to be disclosed:

☐ Mental Health Assessments ☐ Demographic Information ☐ Neuropsych. Evals

☐ Psychiatric Assessments ☐ Psychiatric Progress Notes ☐ Lab Results

☐ Medication List ☐ Clinician Progress Notes ☐ School Records/IEPs

☐ Treatment Plans ☐ Case Management Notes ☐ Physical Exams

☐ Verbal Exchange of Info ☐ Discharge Summary ☐ Immunization Record

☐ All Patient Records ☐ Other (Specify): ______________________________

Purpose of Disclosure(s)

Please check or initial the purpose of disclosure:

☐ Legal Request ☐ Insurance Claim ☐ Further Treatment

☐ Other (Specify): ____

Authorization for Release of Information

Expiration Date

This authorization will expire on _______________, or 6 months following the date of discharge from any *Denali Family Services* program, revocation of custody or guardianship, or upon written revocation, whichever comes first.

This authorization may be revoked prior to the expiration, but not retroactively. If you wish to revoke a release of information, please compose a letter stating such to *Denali Family Services* with attention to the Medical Records Department.

If no date is entered above, this authorization will expire one year from signature.

Disclaimers

- This information may be used for continuation of care.
- I have the right to receive a copy of this signed release of information.
- Photostatic and/or facsimile copies of this authorization will be considered as valid as the original.
- Treatment, payment, enrollment, or eligibility benefits will not be denied based off refusal to sign this release of information.
- I acknowledge that the information released is protected by Federal law and may include information regarding Mental Health, Drug/Alcohol Abuse, Sexually Transmitted Diseases, HIV, and Hepatitis.
- Information used or disclosed pursuant to the release of information may be subjected to redisclosure by the recipient and may no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure information related to: HIV/AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.
- More information about your rights under HIPAA can be found on the U.S. Department of Health and Human Services website.

Authorizing Signature(s)

Authorizing Signature: ______________________________________ **Date:** ______________

Name: ______________________________________ **Relationship:** ____________________
First Last M.I. *(Legal Guardian, Stepparent, etc.)*

Secondary Signature (if applicable): ___________________________ **Date:** ______________

Name: ______________________________________ **Relationship:**____________________
First Last M.I. *(Legal Guardian, Stepparent, etc.)*