Eagle | River Behavioral Health

AUTHORIZATION FOR RELEASE OF INFORMATION

This form is used for patient's to share Protected Health Information (PHI) with an authorized individual or entity. Eagle River Behavioral Health recognizes a patient's rights to access protected health information. This Release of Information facilitates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164. For questions about HIPAA or this form please contact our office at (907) 726-0378.

Patients Name: ______________________________ Date of Birth: ______________

Address: ______________________________ Phone: ______________

I, ______________________ , authorize Eagle River Behavioral Health to:
[Patient or Legal Guardian]

☐ Disclose Info ☐ Obtain Info ☐ Exchange Info

to/from ______________________ ______________________ ______________
[Person, Clinic, or Entity] [Address] [Phone]

the following information (please check all the apply):

☐ Medical Record
☐ Discharge Summary
☐ Scheduling Appointments
☐ Diagnostic Reports (Labs, EKG, etc.)
☐ Psych Evaluation/Progress Notes
☐ Date Range: ________ to ________
☐ Verbal Exchange Only
☐ Other (please specify): ______________________________

By: ☐ Mail ☐ Fax ☐ Other (please specify): ______________

Purpose: ☐ Treatment Coordination ☐ Personal Record ☐ Legal ☐ Other: ______________

Authorization expires one year from the date of authorization, unless revoked or a shorter duration is specified here: ______________________ .

I hereby authorize the use or disclosure of my health care information as described above. I understand that this authorization is voluntary and that I may request a copy of this signed authorization. I understand that my records may contain sensitive information.

I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received.

I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide this authorization.

I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential.

______________________ ______________ ______________________
Signature of Patient or Legal Guardian Date Relationship, if other than Patient