Glacier Family Medicine Clinic
11724 Seward Highway #D
Seward, AK 99664
(907) 224-8733
Fax (907) 224-8734

Authorization for Release of Information

Name: _____

SSN: _____ Date of Birth: _____

Other Names under which Records Might Be Filed: _____

Person/Organization Releasing Information: _____

Person/Organization Receiving Information: _____

Description of Information to be released: (If substance abuse information is to be released from a federally assisted substance abuse treatment center, then this information must be included in the description.)

_____

_____

_____

The Purpose of the release of this Information is: _____

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information. I understand I may revoke this authorization at any time by signing the revocation section on the back of this release, or by notifying the individual(s) or organization releasing the 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 (if applicable) 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. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event: _____

_____ _____

Signature of Client or Personal Representative (Or Witness if signature is by mark) | Date

_____ _____

Printed Name of Personal Representative or Witness | Description of Personal Representative's Authority

NOTE: This authorization was revoked on: _____ (See reverse or attached revocation)

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part2. A general authorization for the release of medical or other information is held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL