AUTHORIZATION TO RELEASE RECORDS OR INFORMATION

I AUTHORIZE:

MY HOUSE
300 N WILLOW ST.
WASILLA, AK 99654
PH: (907)373-4357
FAX: (907)308-6825

Release To:_____ Obtain From:_____ **Please Initial**

_____
Name of Person or Agency

_____
Street Address

_____
City State Zip Code

PH:_____ Fax:_____

Information to be released:
From (date) _____ To (date) _____

INITIAL all that apply:

____ Discharge Summary	____ Therapy Notes
____ Intake Summary	____ Medications
____ SUD/MH Assessment	____ Case Management
____ Psychiatric Evaluation	____ Community Support Services
____ Treatment Plan	____ Verbal

____ Other:

_____

_____

Receive by: Mail ____ Fax ____ Pick Up ____ Verbal ____ Electronic ____
Purpose of the Request: Treatment _____ Legal _____ Insurance _____ Personal_____ Other _____

**I understand that information in the Health Record may contain information relating to mental health or behavioral health, alcohol and drug abuse, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).*
**I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.*
**I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations*
**I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.*
**I understand I have the right to receive a copy of this authorization form. I also understand that upon my written request, MY House must provide me a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes.*

Client Name (Please Print) _____
Date of Birth: _____ Phone Number: _____
Client Signature: _____ Date: _____
Parent/Guardian: _____ Date: _____
Witness: _____ Date: _____
This authorization will terminate one year from the date signed, or unless an earlier date or condition / event is specified here:
_____

Recipient Information: if the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) Prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose.

This authorization is revoked: _____ Date: _____