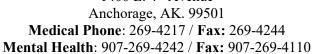


ALASKA DEPARTMENT OF CORRECTIONS AUTHORIZATION for RELEASE of PERSONAL HEALTH CARE **INFORMATION**

Health Information Services 1400 E. 4th Avenue





Patient Name	Birth date:	SSN:
I request and authorize to release (in Records released From/To: Name/Agency: Address:	n written and/or oral format) the information specifie Records release Name/Agency: Address:	
Phone: Fax:	Phone:	Fax:
Specific information to be re Records or Information to be rele		_ To:
Admission Records	Immunization History	Drug & Alcohol
Diagnostic Reports	Laboratory Results	Psychiatric Evaluations
☐ Discharge Reports	☐ Medical History/Records	Substance Use Screening, Assessments & Evaluations
HIV Status/Treatment	Medical Screening & Assessments	Consultations
STD Status and Treatment	☐ Medications (please attach list)	☐ Treatment Plan
Mental Health & Psychiatric Evaluations	Behavioral Health Screening, Assessments & Evaluations	Other (specify):
Disclosure is being made for the purification Continuing Medical Care	rpose(s) listed below: Legal Other (please specify):	Judicial/Court
must do so in writing and present m will not apply to information that has this authorization will expire on the expiration date, event, or condition, health care provider; the released in (Initial) I understand that the information to other parties is strictly diagnosis and/or treatment for me were the solution of the parties in the information to other parties is strictly diagnosis and/or treatment for me were the solution of the parties in the solution of the parties is strictly diagnosis.	this authorization will expire in sixty (60) days. I unformation may no longer be protected by the federal e use of this information for any reason other than sty prohibited except to those parties contracted by the	ices Department. I understand that the revocation ation. I further understand unless otherwise revoked. If I fail to specify a derstand if the requester is not a health plan or privacy regulations and may be re-disclosed. Itated above is prohibited and that disclosure of this e Department of Corrections to assist in providing
Signature		Date
law (CFR 42 Part 2) prohibiting you frowhom it pertains or as otherwise permit	formation released pertains to alcohol or drug abuse, the or m making any further disclosure of this information without the description of the release. The federal rules restrict any use of the information to critical states.	out the specific written authorization of the person to ase of medical or other information if held by another

DOC, Form 807.06A Rev: 08/28/19

 $Health\ Information\ Services,\ Anchorage\ Correctional\ Complex\ East,\ 1400\ E.\ 4^{th}\ Ave.,\ Anchorage\ Alaska\ 99501\ Phone:\ (907)269-4217\ Fax:\ (907)269-4244$