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

Health Information Services
1400 E. 4th Avenue
Anchorage, AK. 99501
Medical Phone: 269-4217 / **Fax:** 269-4244
Mental Health: 907-269-4242 / **Fax:** 907-269-4110

Patient Name_____ **Birth date:**_____ **SSN:** _____

I request and authorize to release (in written and/or oral format) the information specified below;

Records released From/To:
Name/Agency: _____
Address: _____
_____
_____
Phone: _____ Fax: _____

Records released To/From:
Name/Agency: _____
Address: _____
_____
_____
Phone: _____ Fax:_____

Specific information to be released: Dated from: _____ **To:** _____

Records or Information to be released (Please check all that apply)

☐ 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 purpose(s) listed below:

☐ Continuing Medical Care	☐ Legal	☐ Judicial/Court
☐ Insurance	☐ Other (please specify):	

_____(Initial) I understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I further understand unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in sixty (60) days. I understand if the requester is not a health plan or health care provider; the released information may no longer be protected by the federal privacy regulations and may be re-disclosed.

_____ (Initial) I understand that the use of this information for any reason other than stated above is prohibited and that disclosure of this information to other parties is strictly prohibited except to those parties contracted by the Department of Corrections to assist in providing diagnosis and/or treatment for me while I am incarcerated.

_____ (Initial) I authorize the use of a telefax (FAX) of this form to be used as the original for the release or disclosure of the information.

Signature_____Date_____

Witness_____Date_____

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 or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if 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.

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