CHUGACHMIUT

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ______________________________ Date of Birth:______________

Patient Address: ____

Phone #: ______________________________

I am requesting information from:

Facility Name(s)	Phone Number and/or Fax Number

To be released to:

Facility Name(s)	Phone Number and/or Fax Number

USE OF INFORMATION

The information will be used/disclosed for the following purpose:

☐ At the request of the client; or

☐ Other (describe in detail): ____

FORM OF INFORMATION

☐ I authorize Chugachmiut to disclose copies of my records as described in this form.

☐ I authorize Chugachmiut and its staff to verbally discuss my records as described in this form.

TYPE OF INFORMATION

DATE RANGE OF RECORDS: ________________ TO ________________________

I authorize disclosure of the following PHI:

☐ History & Physical ☐ Discharge Summary

☐ Operative Report ☐ Emergency Department Report

☐ Diagnostic Reports (lab, x-ray, EKG, etc.)

☐ Other (specify): ____

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LENGTH OF AUTHORIZATION

Unless revoked, this authorization expires on: ___________________________________
If left blank, this authorization will expire 365 days from the date of the client's signature.

APPLICABLE LAW

By signing this authorization form, I understand and agree that:

- My PHI is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent except for certain purposes allowed by HIPAA as described in Chugachmiut's Notice of Privacy Practices.
- My PHI may include my social security number.
- If the person or entity receiving the PHI is not a health care provider or health plan covered by HIPAA, the PHI may redisclosed without protection by HIPAA, but may be covered by other laws protecting information on HIV/AIDS, mental health services, or genetic testing.
- I may revoke this authorization in writing at any time by notifying Chugachmiut, except to the extent that Chugachmiut has already used or disclosed information in reliance on my authorization.
- Chugachmiut may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except in certain circumstances provided by HIPAA.
- I may request a copy of this authorization. Chugachmiut will also provide me a copy if it sought this authorization from me.

SIGNATURE

____ ____________________
Signature of Patient Date

____ ____________________
Signature of Parent, Legal Guardian or Personal Representative Date

____
Printed name of Parent, Legal Guardian or Personal Representative

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Description of Authority (if applicable)

**Note: Chugachmiut requires Legal Guardians and Personal Representatives to provide written verification of their authority to act on behalf of a patient.*

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For Chugachmiut's Use Only:

Date Received: ___________________________

Name/Title of Staff Member Processing Request: _______________________________________

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