CHUGACHMIUT
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Phone #: _____

I am requesting information from:

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

To be released to:

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

PURPOSE OF USE/DISCLOSURE

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

- ☐ At the request of the patient; 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 discuss my care with the individual(s)/facility(s) identified in this form.

TYPE OF INFORMATION

DATE RANGE OF RECORDS: _____ TO _____

I authorize the disclosure of the following PHI:

☐ History & Physical ☐ Discharge Summary ☐ Behavioral Health Assessment ☐ Diagnosis

☐ Operative Report ☐ Emergency Department Report ☐ Treatment Plan

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

☐ 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 patient'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 limited circumstances provided for by HIPAA.

SIGNATURE

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, Legal Guardian or Personal Representative Date

_____
Printed name of Parent, Legal Guardian or Personal Representative

_____
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: _____