



**HEALTH INFORMATION MANAGEMENT
AUTHORIZATION TO DISCLOSE PROTECTED
HEALTH INFORMATION**

This form is for release of information requests to third parties. Please allow up to 30 days for SEARHC to process your request. Incomplete forms will be returned. There may be a fee associated with processing the request. Staff will inform you if the fee applies.

Printed Name of Child Patient:	Previous Names (if applicable):
Date of Birth (MM/DD/YYYY):	Daytime Telephone Number:

INFORMATION TO BE RELEASED FROM:	SEND INFORMATION TO:
Provider Name/Organization: SEARHC (If Primary Physician: _____)	Name of Person/Facility/Organization: Central Council Tlingit & Haida Indian Tribes of Alaska - Head Start
Address: 3100 Channel Drive Ste. 300 Juneau, AK 99801	Address: P.O. Box 25500 Juneau, AK 99802
Contact Number: 907-463-6630	Contact Number: 1.800.344.1432/907.463.7127
Fax Number: 907-463-4012	Fax Number: 1.877.389.7796

Format in which you would like the recipient to receive your records: Mail Fax: Pick Up Verbal Encrypted Email

REQUIRED INFORMATION

PURPOSE OF DISCLOSURE:

Transfer of Care Disability Law Enforcement Specialist Referral
 Attorney Head Start School Insurance Other: _____

INFORMATION TO BE DISCLOSED:

Medical records from the last two years Complete Designated Record Set
 Date(s) of Service: ____/____/____ through ____/____/____

Health Summary Specialist records Emergency room records
 Discharge summary Physician progress notes Nursing notes
 Laboratory/pathology reports Radiology reports Radiology images
 Medication list Immunization record Accounting of disclosures
 Dental chart note Dental Pano X-ray Dental X-ray

Other: **Head Start Physical Exam Form** (Including: Growth measurement, Blood Pressure, Vision, Hearing, TB, Hemoglobin/Hematocrit, Physical/Developmental Assessment, allergies and chronic illness), & **Head Start Dental Exam Form** (Including: Procedures Performed, Caries Risk Status, Current Oral Health Status, Recommendations, & Treatment Plan)

Printed Name of Patient: _____

Disclosures Requiring Special Consent:

If your records contain any of the information listed below, please initial next to that information to indicate that we are allowed to release these type of records:

____ HIV/AIDS Virus ____ Mental Health/Psychiatric Disorders ____ Sexually Transmitted Diseases
____ Substance Use/Treatment

This form may be revoked at any time by submitting a written request to the address below, provided the information has not already been disclosed. This authorization expires 180-days from date of signing unless an alternate expiration date or event is indicated (not to exceed one-year.)

Alternate expiration date/event: 1 Year from date of signature

We will not condition or deny treatment on completion of this authorization. Please be aware that once we disclose this information, the information is subject to re-disclosure and may no longer be protected by HIPAA.

I have read and understand this form and authorize the information to be released as indicated.

Signature of parent, guardian or personal representative

Relationship to patient

Date

ID # _____

**Legal documentation may be required to confirm the authority or the personal representative.*

SEARHC HIM DEPARTMENT
3100 Channel Dr., Suite 300
Juneau, AK 99801
P: 907-463-6630 F: 907-463-4012

For Facility Use:

Date Received: Date Released: MRN #: Acct #: ROI #: Released by: