SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

HEALTH INFORMATION MANAGEMENT
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH

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 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**	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:** 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 __**X**__Fax__Pick Up_____Verbal
_____Encrypted Email_____Unencrypted email (there is a risk that your records may be intercepted or viewed if sent unencrypted.) Email address: _____

REQUIRED INFORMATION

PURPOSE OF DISCLOSURE:

_____Transfer of Care _____Disability _____Law Enforcement _____Specialist
_____Attorney __X__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 _____Billing records _____Emergency room records
_____Discharge summary _____Physician progress notes _____Nursing notes
_____Laboratory/pathology reports _____Radiology reports _____Radiology images
_____Medication list __X__Immunization record _____Accounting of disclosures
_____Dental chart note _____Dental Pano X-ray _____Dental X-ray
__X__Other: ***Head Start Physical Exam Form*** (*Including: Grow 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*)

rev. 2024-4-16 TD/2019-03-21-FIN-REV-HIM 015

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 90-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 Patient 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: