Presbyterian Hospitality House

Release of Information Authorization

Administrative Center
209 Forty Mile Avenue, Suite 100
Fairbanks, Alaska 99701
907-456-6445 – 907-456-6402 (FAX)

Mat-Su Regional Office
1365 Parks Highway, Suite 101
Wasilla, Alaska 99654
907-357-6445 – 907-376-6402 (FAX)

I,_____ DOB:_____ SS#:_____
(Youth's Name)

hereby authorize Presbyterian Hospitality House:

☐ to Exchange with	(Name of Person/Agency)
☐ to Release to	(Address, City, State, Zip Code)
☐ to Exchange verbal information with	(Phone Number, Fax Number)

1. The following specific information: Please initial by each X that you authorize us to exchange or release.

☑ Behavioral Health Assessment	☑ Social History	☑ Treatment Plan
☑ Psychiatric Evaluation	☑ Medical History & Physical	☑ Treatment Plan Reviews
☑ Substance Abuse Assessment	☑ School Records	☑ Discharge Summary
☑ Neuropsychological Evaluation	☑ Special Education Records	☑ UA Results
☑ Medication Sheets	☑ Immunization Records	☑ Incident Reports
☑ Verbal Exchange of Information	☑ Progress Notes	☐ Other: _____

2. The purpose of the release of this information is:

☐ Sharing with other health care providers as needed ☐ Insurance/Billing Purposes

☐ My personal records ☐ Legal Other – Please specify treatment planning

I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Exchange of information ensures continuity of care between providers. By not sharing information, my health care could be compromised.

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any effect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential.

3. This authorization expires on the following date or event: _____ or 360 days from the date of signature if no other date or event is indicated. Photo static and/or facsimile copies of this authorization will be considered as valid as the original.

Youth Date

Parent/Legal Guardian Relationship to client Date

PHH Staff/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.

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