State of Alaska

Department of Health and Social Services
Division of Senior and Disabilities Services

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____

Medicaid # _____ Record # or Other ID: _____ Date of Birth: _____

Other Names Under Which Records Might Be Filed: _____

Person/Organization Releasing Information: Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf and _____
(name of ICAP Respondent or Care Coordinator may be inserted. ***Note** if text box is not used insert "N/A"; if text box is used, do not use this form to request any records or information except from the person or agency named in the text box)

Person/Organization Receiving Information: (*include address if needed*) Alaska Department of Health and Social Services, Senior & Disabilities Services and Pathfinder Care Coordination (name of Care Coordinator or PCS Agency representative or ADRC or DDRC representative may be inserted)

Description of Information To Be Released: *(If substance abuse information is to be released from a federally assisted substance abuse treatment center, then this information must be included in the description)* **health care provider notes (excluding psychotherapy notes, as defined by HIPAA), history & physical records, admission notes, discharge summaries, discharge plans, notes from clinic visits, laboratory records and reports, imaging and radiology records and reports, swallow studies, inpatient and outpatient records, physical therapy records, occupational therapy records, respiratory therapy records, dialysis records, chemotherapy records and the personal knowledge of respondents or agencies named in my ICAP application if applicable. Note* release records that are current within the previous 12 months from the date of the request.** *The purpose of the release of this information is: to obtain health care records and financial information needed to determine eligibility to receive or continue to receive services and other benefits through programs managed by the State*

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 my records *may* contain sensitive information. 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 affect 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. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event: When services end with Pathfinder Care Coordination

_____ _____
Signature of Client or Legal Representative Date
(Or Witness if signature is by mark)

_____ _____
Printed Name of Legal Representative or Witness Description of Legal Representative's Authority

NOTE: This authorization was revoked on: _____(Date)(see attached revocation)