State of Alaska
Department of Health and Social Services
Division of Senior & Disabilities Services
550 West 8th Ave ● Anchorage, Alaska 99501
(907) 269-XXXX ● 1-800-478-XXXX

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: ____

Record # or Other ID: ______________________________ Date of Birth: ______________________________

Other Names under which records might be filed: ____

Person/Organization Releasing Information: ____

Person/Organization Receiving Information: ____

____

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)*

____

____

The purpose of the release of this information is: ____

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 signing the revocation section on the back of this release, or 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 *may* 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: ____________________________________

______________________________	______________________________
Signature of Client or Personal Representative (Or Witness if signature is by mark)	Date
______________________________	______________________________
Printed Name of Personal Representative or Witness	Description of Personal Representative's Authority

NOTE: This authorization was revoked on: __________________ *(see reverse or attached revocation statement)*
Date

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

REVOCATION SECTION

I do hereby request that this authorization to release the information of: ____
(Printed Name of Client)

described on the reverse side of this form, be rescinded, effective ______________________. I understand that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

____
Signature of Client or Personal Representative
(Or Witness if signature is by mark)

____
Date

____
Printed Name of Personal Representative or Witness

____
Description of Personal Representative's Authority

____
Signature of Staff

* This Revocation Section must appear on the reverse side of DHSS Authorization for Release of Information 06-5870 (03/03) and is invalid if used separately. If a separate form is required, use DHSS Revocation of Authorization for Release of Information 06-5872 (03/03). If this revocation section has been completed and signed, please note the date of the revocation on the reverse side of this form in the space provided.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL