Authorization for Exchange of Information

AK Child & Family

I hereby authorize AK Child & Family to exchange personal health information between AK Child & Family

and Name: ____ Fax: ____

Address: ____

for Student Name: __________ Date of Birth: ______________________

PLEASE RETURN FORM TO: ATTENTION:____

AK Child & Family • 4600 Abbott Road Anchorage, AK 99507 • (907) 346-2101 • Fax (907) 348-9230

INFORMATION TO BE RELEASED / REQUESTED FOR THE FOLLOWING PURPOSE:

☐ Treatment ☐ Legal Request ☐ Insurance Claim ☐ Other: _______________

Please check specific information to be released:

☐ Progress Notes
☐ Consultations
☐ Neuropsychological Assessment
☐ Psychological Assessment(s)
☐ Treatment Plan and Review(s)
☐ Intake / Mental Health Assessment
☐ Psychiatric Assessment
☐ Substance Abuse Assessments
☐ Discharge / Continuing Care Summary
☐ Medical History / Physical Exam
☐ Medical / Dental Aftercare Plan
☐ Medical and Laboratory Results
☐ Physician Orders
☐ Verbal exchange of all information to aid in assessing and / or treating student
☐ UA Results
☐ Other: ____
☐ School Records *(Transcripts, Disciplinary Reports, IEP, Other Plans)*
☐ Immunization Records
☐ Special Education Records

This information may be used for continuation of care. I understand this authorization will expire on ________________ and / or **6 months following the date of discharge from any AK Child & Family,** revocation of custody or guardianship, or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photo static and / or facsimile copies of this authorization will be considered as valid as the original.

PROHIBITION ON REDISCLOSURE: *This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations restrict any use of this information to investigate or prosecute any alcohol or drug abuse patient. Disclosure of patient information is permitted with the patient's written consent: however, disclosures to central registries and in connection with criminal justice referrals must meet the following specific regulations: (42 CFR 2.32 and 2.33). This information disseminated from AK Child & Family.*

I acknowledge that the information to be released is protected by Federal law and may include information regarding drug / alcohol abuse, sexually transmitted diseases / HIV and / or Hepatitis B. My signature below authorizes the release of this information.
I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment.
I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Student: ____ Date: ______________________

Parent / Guardian: ____ Date: ______________________

Witness: ____ Date: ______________________