# Authorization for Exchange of Information

**AK Child & Family** **Student Name**

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

**and** Name: Business / Person Name _____ Fax: _____

Address: _____

**for** Student Name: Student Name Date of Birth: MM-dd-YYYY

**PLEASE RETURN FORM TO: ATTENTION:** Return this form to who? _____

**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 (excludes Psychotherapy)
- ☐ Medication Management
- ☐ Neuropsychological Assessment
- ☐ Psychological Assessment
- ☐ Treatment Plan and Review(s)
- ☐ Intake / Mental Health Assessment
- ☐ Psychiatric Assessment
- ☐ Substance Abuse Assessments
- ☐ Psychotherapy Notes (IT, FT, and GT)
- ☐ 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
- ☐ Other: _____
- ☐ School Records *(Transcripts, Disciplinary Reports, IEP, Other Plans)*
- ☐ Immunization Records
- ☐ UA results

This information may be used for continuation of care. I understand this authorization will expire on MM-dd-YYYY 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: _____

Revocation Notice: Except to the extent that action has already been taken in reliance on this authorization, at any time may revoke this authorization by signing below.

I do hereby request that this authorization to release the information for Student Name _____as described above

be rescinded effective MM-dd-YYYY _____, except to the extent that the action has already been taken.

_____ _____ _____

Signature of Client/Parent/ Guardian Printed Name of Client/ Parent/Guardian Relationship