

**State of Alaska**  
**Department of Health & Social Services**  
**Division of Public Health**

AUTHORIZATION FOR RELEASE OF RESIDENT INFORMATION (AS 47.33.070)

Regarding: \_\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby request and authorize \_\_\_\_\_ and \_\_\_\_\_  
to exchange information pertaining to me as specified below. The purpose of the release of this information  
is \_\_\_\_\_

Information Requested	Date	Date or Years Covered	Res/Rep Initials	Information Requested	Date	Date or Years Covered	Res/Rep Initials
School Evaluations			*	Medical Records			*
Other Academic Information			*	Psychosocial Evaluations			*
Psychological Evaluations			*	Substance Abuse Treatment Records			*
Psychiatric Evaluations			*	Past Employment History			*
Social History			*	Financial Records			*
Hospital Records & Discharge Summaries			*	Most Recent Treatment Plan or Assisted Living Plan (IHP, IEP, IPP, etc.)			*
Other (Specify)							

Please initial by \*

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 of this release, or by notifying the individual(s) or organization releasing this information in writing. I understand this revocation will not 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: \_\_\_\_\_

\_\_\_\_\_  
Signature of Resident or Resident's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Resident's Representative's Authority

**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.

*NOTE: This authorization was revoked on: \_\_\_\_\_ (see reverse or attached revocation)*

**REVOCATION SECTION**

I do hereby request that this authorization to release the information of: \_\_\_\_\_  
(Printed Name of Resident)  
described on the reverse side of this form (or attached), be rescinded effective \_\_\_\_\_  
(Date)

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

\_\_\_\_\_  
Signature of Resident or Resident's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Resident's Representative's Authority

\_\_\_\_\_  
Signature of Staff

\_\_\_\_\_  
Date