Submit Completed Forms to
DSM: admin@cpdalaska.directak.net
FAX: 907-600-5124
Email: aoneill@cpdalaska.org

Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, consistent with Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

Use and Disclosure of Health Information

I hereby authorize the use or disclosure of my health information as follows:

Consumer: ____

Persons/Organizations authorized to *receive or disclose* the information: ________________ ________________

Persons/Organizations authorized to *receive or disclose* the information: ________________________________

Purpose of requested use or disclosure: ____

By checking below, I authorize disclosure of the following types of health information:

- ☐ Neuro/Psychological Evaluations
- ☐ Psychiatric Evaluation Reports
- ☐ Intake Summaries
- ☐ Discharge Summaries
- ☐ Treatment Plans
- ☐ Social History
- ☐ Progress Reports
- ☐ Physical/Medical Records (Med's)
- ☐ School Transcripts
- ☐ Other:___________________________
- ☐ Individual Education Plan (IEP)
- ☐ IEP Three Year Re-evaluation
- ☐ IEP Annual Review
- ☐ Multidisciplinary Evaluations/LD Reports
- ☐ Other Academic Information
- ☐ Police Reports
- ☐ Court Records
- ☐ Verbal Exchange of Information
- ☐ E-mail Exchange of Information
- ☐ Plan of Care
- ☐ Incident reports

This Authorization is in effect: __ Until treatment is complete __ For 1 year from date __ For 6 months from date

Notice of Rights and Other Information

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the Center for Psychosocial Development.

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to a copy of this authorization.

Neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide authorization.

Information disclosed pursuant this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Signature

Date: ____________________ Time: _________________________ am/pm

Signature: ____

(*client/representative/spouse/financially responsible party*)

Witness: ____