

GREATLAND CLINICAL ASSOCIATES

1400 W. Benson, Suite 315

Anchorage, AK 99503

Office: (907)929-4009

Fax: (907)929-4902

Authorization for Release of Information

Patients Name: _____ Date of Birth: _____ Last two digits of social security # _____

I, the client parent legal guardian, hereby authorize Greatland Clinical Associates to: Obtain from and/or Release to:

Person/Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Records dated between: _____

The purpose of this Disclosure/Information (Initial your choices):

_____ Continued Treatment _____ Treatment Planning _____ Personal Use _____ Legal Use _____ Other: _____

Information Authorized for Release (Initial each that applies):

_____ Psychiatric Evaluation	_____ Verbal Exchange of Information	_____ ALL RECORDS (within above dates)
_____ Initial Mental Health Assessment	_____ Attendance / Compliance / Appointments	_____ Medication Tracking Sheet
_____ Psychiatric Progress Notes	_____ Vocational / Work Information Notes	_____ History and Physical / Medical Notes
_____ Mental Health Progress Notes	_____ Admission / Discharge Summaries	_____ Laboratory / Radiology Reports
_____ Psychological Testing / Reports	_____ Treatment Plan	_____ Emergency Reports
_____ Other: _____		_____ School Records

_____ I understand that the released information may include:

Alcohol / Substance Abuse Records, Mental Health Records, and HIV Status

_____ I authorize the use of telefax (Fax) of this form as the original for the release or disclosure of the information requested. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment, payment, enrollment, or eligibility of benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Greatland Clinical Associates to complete the process. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Without a written cancellation this authorization will remain in effect for 1 year unless an earlier date or condition/event is specified here: _____

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____

For Minors	
_____	_____
Signature of Legal Guardian/Relationship	Date
_____	_____
Printed Name of Parent/Legal Guardian	Date

GREATLAND CLINICAL ASSOCIATES PROVIDERS initial action to be taken:	
_____ Send for ROI	_____ Send ROI Only
_____ Release GCA Records	_____ File ROI Only

FOR OFFICE USE ONLY:	
Date Sent: _____	By Whom: _____
Unable to Process Due to: _____	