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	_____ Medication Tracking Sheet
_____ Initial Mental Health Assessment	_____ Attendance / Compliance / Appointments	_____ History and Physical / Medical Notes
_____ Psychiatric Progress Notes	_____ Vocational / Work Information Notes	_____ Laboratory / Radiology Reports
_____ Mental Health Progress Notes	_____ Admission / Discharge Summaries	_____ Emergency Reports
_____ Psychological Testing / Reports	_____ Treatment Plan	_____ School Records

_____ ALL RECORDS (within above dates)

_____Other:_____

_____ **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:		FOR OFFICE USE ONLY:
_____Send for ROI	_____Send ROI Only	Date Sent: _____ By Whom:_____
_____Release GCA Records	_____File ROI Only	Unable to Process Due to: _____