

GREATLAND CLINICAL ASSOCIATES

1400 W. Benson, Suite 525
Anchorage, Alaska 99503
OFFICE: 907.929.4009 FAX: 907.929.4902

AUTHORIZATION OF RELEASE OF CONFIDENTIAL INFORMATION

CLIENTS NAME: _____	Date of Birth: _____
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Requesting Entity : <u>Greatland Clinical Associates</u>	Releasing Entity: _____
_____	_____
Street Address	Street Address
_____	_____
City / State / Zip	City / State / Zip
(907) 929-4902 (907) 929-4009	
_____ / _____	_____ / _____
Fax Phone	Fax Phone

_____ (initial) I authorize this release to be reciprocal between the two parties.
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INFORMATION AUTHORIZED FOR RELEASE

_____ <input type="checkbox"/> Psychological Evaluations/Reports	_____ <input type="checkbox"/> Social History
_____ <input type="checkbox"/> Psychiatric Evaluations/Reports	_____ <input type="checkbox"/> Vocational/ Work Information
_____ <input type="checkbox"/> Physical / Medical Records / Med. List	_____ <input type="checkbox"/> Discharge Summary (ies)
_____ <input type="checkbox"/> Lab Results	_____ <input type="checkbox"/> Verbal Information
_____ <input type="checkbox"/> Radiology Reports (CT/MRI)	_____ <input type="checkbox"/> Information regarding HIV Status
_____ <input type="checkbox"/> Emergency Reports	_____ <input type="checkbox"/> Information regarding Chemical

____ I hereby authorize the above information to be released to the party I have indication for the purpose of:
continuity of care _____ other: _____

I retain the right to revoke this authorization in writing prior to the expiration date below.

*Treatment may not be conditioned on obtaining the authorization if that is prohibited by the HIPPA Privacy Rule.
The information disclosed pursuant to this authorization may be subject to re-disclosure by the designated recipient,
and subsequently no longer protected by the HIPAA Privacy Rule.*

Signature of Client or Client's Designee

Designee's Relationship to Client

Witness

_____ TO _____
Date Authorized Date Authorization ends