# GREATLAND CLINICAL ASSOCIATES

**1400 W. Benson Blvd., Suite 315, Anchorage, AK 99503**
Phone: **(907) 929-4009** Fax: **(907) 929-4902**

## ROI: RELEASE OF INFORMATION AUTHORIZATION

Patient's 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 your choices*):** **____ALL RECORDS**

____Psychiatric Evaluation _____Verbal Exchange of Information ____Medication Tracking Sheet

____Initial Mental Health Assessment _____Attendance/Compliance/Appointment ____History & Physical/Medical Notes

____Psychiatric Progress Notes _____Vocational/Work Information Notes ____Laboratory/Radiology Reports

____Mental Health/Therapy Notes _____Admission/Discharge Summaries ____Emergency Reports

____Psychological Testing/Reports _____Treatment Plan ____School Reports

____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 may 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 on earlier date or condition/event is specified here:* ______________________________________ ***OR*** ☐ **AUTHORIZATION GRANTED INDEFINITLY**

Signature of Patient __________________________________Date _____________

Signature of Witness__________________________________Date _____________

**For Minors/ Wards**

Signature of Legal Guardian Date

Printed Name of Legal Guardian Date

Legal Guardian's Relationship to Patient

**GREATLAND CLINICAL ASSOCIATES PROVIDERS** ➔ ***Please select requested action for GCA Front Desk:***

☐ Scan & Shred ☐ Scan, Send (no records requested at this time), & Shred

☐ Request Records ☐ Release GCA Records ◆ *If we are to Request or Release records, please specify*:

All, last 3 + eval, or specific dates/ records ____________________

**FOR OFFICE USE ONLY:**

Date Sent: __________________ By Whom: ___________________________ Unable to process due to: ________________________________