KODIAK AREA NATIVE ASSOCIATION

HEALTH SERVICES

Authorization for Use and Disclosure of Health Information

All information must be completed fully and accurately before health records are released.

Patient Name (Last Name, First):			MI:
Telephone Number:	DOB:		
Patient Address:	City:	State:	Zip:

REQUESTOR MUST PROVIDE A LEGIBLE COPY OF LEGAL IDENTIFICATION ALONG WITH THIS FORM

The information is to be disclosed by		And is to be provided to:	
Name of Facility:		Name of Person/Facility/Organization	
Address:		Address:	
City, State, Zip		City, State, Zip	
Phone #:	Fax #:	Phone #:	Fax #:

I authorize the following information to be released to/from KANA:

☐Records for the following dates: _____ to _____

☐Only information related to (specific injury, accident or particular illness/treatment):_____

☐Other information specified on reverse side of this form;

☐Other information specified below;

Description of specific information to be disclosed, please place a ☒in all applicable box(es) below:

_____ Immunization Records _____ Radiology reports _____ Lab/pathology Reports

_____ Medication Lists _____ Nursing assessments _____ Other (*please specify below*)

_____

The information will be disclosed for the following purposes (requestor MUST choose one of the following):

Insurance Disability Attorney School

Law Enforcement Personal use Military Use Transferring care to other clinic

The information will be disclosed by: _____ In person _____ Mail _____ Fax

_____ email* to the following email address: _____

*Sending information by email increases privacy risks, as they involve increased risk of accidental disclosure

I understand that information disclosed by this authorization may be subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Parts 160 & 164) and the Privacy Act of 1974 [5USC 522a.]. I understand that I may request a copy of this authorization. I understand that a photocopy/fax of this authorization is as valid as the original. I understand that health information released, if covered by federal law 42 S.F.R. Part 2 (Alcohol & drug abuse records); will continue to be protected by law from re-disclosure. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment for my eligible benefits.

I understand that this authorization is valid 1 year form the signature date. I understand that I may revoke this authorization by submitting in writing a request to Health Information Services Kodiak Area Native Association, except to the extent that action has been taken on it.

Signature: _____ **Date:** _____

Relationship to Patient: _____

OFFICE USE ONLY:

Patient Record #: _____ Verification Method: _____ Date Sent to HIM: _____ Staff Initials: _____

Date Received at HIM: _____ Staff Initials: _____ Date Scanned in Record: _____

Date Copied: _____

Authorization for Use and Disclosure of Health Information

Complete ONLY if you would like any of the following sensitive Drug/Alcohol Treatment, Sexually Transmitted Disease, HIV/AIDS or Mental/Behavioral Health information disclosed.

You MUST INITIAL **all applicable box(es) below:**

	Information related to drug/alcohol treatment
	Information related to treatment for any sexually transmitted disease, including HIV or AIDS
	Information related to treatment for mental/behavioral health related illnesses
	Intake assessment
	Neuropsychological Assessment
	Psychiatric Assessment
	Psychological Assessment
	Treatment Plan
	Treatment Plan Review
	Behavioral Urgent Response Team (BURT)
	Medication List
	Summary of Attendance
	Summary of Participation
	Entire Mental/Behavioral Health Record
	Other Mental/Behavioral Health documentation as specified:

Signature: _____ **Date:** _____

Relationship to Patient: _____

Name (Last, First, MI):	Record Number:
Address:	
City/State:	Date of Birth:

Health Information Management Staff Use Only:

Pages: _____ Date: _____

Method: ☐In person > ☐ID verified
☐Mail
☐Fax
☐Email

Staff Initials: _____