central peninsula hospital

HIM Dept.: (907) 714-4564 FAX: (907) 262-2753 email: medicalrecords@cpgh.org
Imaging Dept.: (907) 714-4580 FAX: (907) 714-4995

REQUEST FROM A THIRD PARTY – AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Patient's Full Name: _____ **Date of Birth:** _____

Former Name(s): _____ Phone #: _____

2. Purpose or need for disclosure:

☐ Ongoing Care ☐ Legal ☐ Insurance ☐ Personal use ☐ Other (specify): _____

3. Records to be released to:

☐ CENTRAL PENINSULA HOSPITAL ATT: _____ FAX #: _____

☐ OTHER: Name:_____

Contact Info: Phone: _____ FAX: _____

4. <u>Records to be released from:</u>

☐ Central Peninsula Hospital
☐ Serenity House Treatment Center
☐ Heritage Place
☐ CP Bone & Joint
☐ CP Diabetes Center
☐ CP Foot & Ankle
☐ CP Gastroenterology
☐ CP Internal Medicine
☐ CP Family Practice & Peds (Soldotna)
☐ CP Mental Wellness
☐ CP Neurology
☐ CP Oncology
☐ CP Spine
☐ CP Surgical Assoc.
☐ CP Women's Health
☐ CP Urology
☐ CP Family Practice (Kenai)
☐ CP Surgery Center (Kenai)
☐ CP Urgent Care (Kenai)
☐ Other: _____

5. Records to be released:

☐ Physician Reports ☐ Complete copy (provide date range) ☐ Billing Records
☐ Lab/Pathology Reports ☐ X-ray reports ☐ X-ray Images
☐ Other: _____

For date(s) of Service: _____

I understand this disclosure is limited to the contents of the CPH Designated Record Set.

I acknowledge that the information being released may be related to sexually transmitted diseases, AIDS, or HIV. My health record may also include information about behavioral or mental health services, and/or treatment for alcohol or drug use.

I understand that this authorization does not include permission to release outpatient Psychotherapy Notes. Release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separate from the rest of the patient's medical record.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization, and 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. In absence of revocation, this specific authorization expires: ☐ 90 days from signature (default), ☐ 1-year from signature, ☐ this is a one-time authorization.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that the released information may not be further protected by federal privacy laws or regulations.

I understand authorizing the use of disclosure of the information identified is voluntary. Refusal to sign this form will not affect my treatment, payment, or eligibility for benefits.

Patient/Representative Signature	**Date**	**Time**	Witness Signature

Relation to Patient: _____