PSYCHOLOGY
R·E·S·O·U·R·C·E·S
Supporting the Emotional Health of Alaskan Families

Authorization to Release and/or Exchange Information

I, _____

On behalf of _____ DOB:_____

Authorize:

Psychology Resources
2600 Denali St., Suite 302
Anchorage, AK 99503

- ☐ To Release information to _____
- ☐ To receive information from _____
- ☐ Exchange verbal information with _____

The following specific information:

☐ Medical/Behavioral Health ☐ Vocational ☐ Special Education ☐ Academic ☐ Legal ☐ Other:

_____

The purpose of the release of this information is:

☐ Sharing with other health care providers as needed and informing treatment
☐ My personal records ☐ Behavioral Health treatment ☐ Legal purpose ☐ Substance abuse treatment
☐ Other- please specify _____

_____

I understand that the information in my health record may include information relating to behavioral or mental health services, and treatment for alcohol and drug abuse. Exchange of information ensures continuity of care between providers. By not sharing information, my care could be compromised.

I hereby authorize the use or discloser of my health care and/or other information as described above. I understand that authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the individuals or organization releasing my information in writing, but if I do it won't have any effect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential.

_____

This authorization expires on the following date: _____
Or 90 days from the date of signature if no other date is indicated.

Signature of Patient/Guardian: _____ Date _____

Signature of Witness: _____ Date _____

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