South Peninsula Hospital

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT IDENTIFICATION:

Name: ______________________ Date of Birth: ______________

Address: ______________________

Phone(s): ______________________ Last four (4) digits Social Security Number: __________

RELEASE FROM:

SPH Facilities:

☐ **South Peninsula Hospital (SPH)**	☐ Long Term Care Facility	☐ Homer Medical Center (HMC)
☐ Family Care Clinic	☐ Neurology Clinic	☐ HMC West-Wing OB/GYN
☐ General Surgery Clinic	☐ Orthopedic Clinic	☐ Serene Waters Mental Health Clinic
☐ Home Health	☐ Sleep Lab/Sleep Clinic	☐ Seaworthy Functional Medicine
☐ Infusion Clinic	☐ Specialty Clinic	

Or Another Facility: Name: ______________________ Phone: ______________

Address: ______________________

RELEASE TO:

Name: ______________________ Phone: ______________ Fax: ______________

(i.e., Self, Physician name, Relative name)

Address: ______________________

INFORMATION TO BE RELEASED:

Please check type of information to be released. Items marked with (*) have additional signature requirements.

From (date): ____________ To (date): ____________

☐ **Complete/Formal Medical Record**	☐ Imaging Reports	☐ Procedure/Operative Notes
☐ Consultation Reports	☐ Encounter/Visit Notes	☐ Progress Notes
☐ Discharge Summary	☐ Itemized Bill	☐ Sleep Study Interpretation
☐ Emergency Dept Report	☐ Laboratory/Pathology Results	☐ PT/OT Therapy Notes
☐ History & Physical	☐ Medication List	☐ Speech Therapy
☐ Imaging CDs	☐ Photographs/Videotapes/CDs	☐ Transfer Summary
☐ *** Drug/Alcohol Treatment**	☐ *** Psychiatric Reports**	☐ ***STI Information**

Receive by:

☐ USPS ☐ Pick-up ☐ Fax: ______________ ☐ Email: ______________

☐ CD ☐ Portable Media (thumb/flash drive provided by SPH) - Preferred Password:______________

Purpose of Request:

☐ Personal (patient request) ☐ Treatment ☐ Legal ☐ Insurance ☐ Government

☐ Other (specify): ______________________

Initials of Requesting Party: __________

Please note that there is the potential for a copy fee. Our policy states that there will be a charge of $20.00 for the first ten (10) pages, then 50 cents for each page thereafter. There may also be a fee of $10.00 or cost (whichever is higher) for postage and handling. There is NO fee for purposes of "treatment" or "insurance" as stated above under "Purpose of the Request".

For Office Use Only

Date Received: __________ Date Completed: __________ # Of Pages Released: ________ Completed By: __________

Information Released: ______________________

Date Sent: __________ Method: __________ ID Checked By: __________

South Peninsula Hospital | 4300 Bartlett St. | Homer, AK 99603 | 907-235-0232, fax 907-235-0252

South Peninsula Hospital

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

TERMS
I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol treatment, psychiatric care or other sensitive information.

EXPIRATION & RIGHT TO REVOKE AUTHORIZATION
Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to the Health Information Management Department.
Unless revoked earlier, **this authorization will expire one year** from the date on which it was signed, or on the following date or event: ______________________________, whichever comes first.

RE-DISCLOSURE
I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

CONSENT OF A MINOR
With certain age restrictions, a minor patient's signature is required in order to release information concerning care for:

1) Pregnancy termination and sexually transmitted diseases
2) Drug or alcohol treatment
3) Mental health conditions

DRUG AND ALCOHOL TREATMENT INFORMATION
Federal regulation (42 CFR part 2) prohibits any further disclosure of this information except with specific written consent of the person to whom the information pertains or the parent/legal guardian of a minor child to whom it pertains, unless otherwise permitted by federal law. A general authorization for the release of information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug treatment patient. Federal regulations state that any person who violates any provision of the law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense. (See 42 USC 290dd-3 and 42 USC 290ee-3).

PSYCHIATRIC / MENTAL HEALTH / MENTAL HEALTH CONSULT(S)
State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or the parent/legal guardian of a minor child to whom it pertains, unless permitted by state law. A general authorization for the release of information is NOT sufficient for this purpose.

SEXUALLY TRANSMITTED INFECTIONS INFORMATION (Includes HIV / AIDS)
State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or the parent/legal guardian of a minor child to whom it pertains, unless permitted by state law. A general authorization for the release of information is NOT sufficient for this purpose. Any violation of the law is a gross misdemeanor, and the law creates civil remedies for any violations which include a $1,000 fine for negligent violation, $2,000 fine for an intentional or reckless violation or actual damages, whichever is greater, and attorney's fees.

A specific authorization is required to disclose information regarding the following:

(Check box and sign to specify information to be disclosed) — Signature

☐ **Drug / Alcohol Treatment** ______________________________

☐ **Psychiatric / Mental Health / Mental Health Consult(s)** ______________________________

☐ **STI Information (Includes HIV/AIDS)** ______________________________

Patient/Representative Signature: ______________________________ Date: __________ Time: __________

Name Printed: ______________________________

If signed by legal representative, relationship to patient: ______________________________