AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Multiparty Form)

I, _____ , _____ , _____ , give consent to
Name *Date of Birth* *SSN*

AICS Medical Clinic
PO Box 1231
Wrangell, AK 99929
Phone (907) 874-4700
Fax (907) 874-4719

☐ to disclose information to (*list below*):
☐ to obtain information from (*list below*):
☐ to disclose information to &: obtain information from (*list below*):

1. _____
2. _____
3. _____

Type of Information: ☐ Only information related to (specify) _____

☐ Entire Record (Does not include items check below)

If checked use separate Authorization for other purposes

☐ Psychotherapy Notes
☐ Substance Abuse Treatment Referral ☐ HIV/AIDS related treatment
☐ Sexually Transmitted Disease ☐ Other (*specify below*)

For the Purpose of:

☐ Further Medical Care ☐ Legal Investigation or Action
☐ Changing Physicians ☐ Personal

☐ Other _____

I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

Should I decide to revoke this authorization prior to its expiration, I understand that I must do so in writing by contacting the AICS Privacy Officer (874-2373).

I understand that the covered entity seeking this authorization may not conditioning treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed.

Signed: _____ _____
Signature *Date*

Witness: _____ _____
Signature *Date*