Please allow up to 7 business days for Maniilaq Association to process your request.

MANIILAQ HEALTH SERVICES
PO Box 43
Kotzebue, Alaska 99752
FAX: 907-442-7315

Incomplete forms cannot be processed.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Name of Patient:	Previous Names, If Applicable:
Date of Birth :	Daytime Telephone Number :

INFORMATION TO BE RELEASED FROM:	**SEND INFORMATION TO:**
Provider Name/Organization:	Name of Person/Facility/Organization:
Address:	Address:
Contact Number:	Contact Number:
Fax Number:	Fax Number:
Format in which you would like the recipient to receive your records: ____Mail _____Fax ____ Pick Up __ Email*	

REQUIRED INFORMATION	*REQUIRED INFORMATION*
PURPOSE OF DISCLOSURE:	**INFORMATION TO BE DISCLOSED:**
_____ Transfer of Care _____ Disability _____ Law Enforcement _____ Specialist _____ Attorney _____ School _____ Insurance _____ Accounting of Disclosures _____ Other:_____ (Do not leave blank)	Date(s) of Service:_____ _____ Medical Records from the last two years _____ Immunization Record _____ Lab Reports _____ Medication List _____ Radiology Reports _____ School Physical _____ Progress Notes _____ Only Information related to (specific injury, accident or particular illness/treatment):_____ _____ _____Other:_____

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and maybe revoked at any time, providing information has not already been disclosed. This authorization expires 180 days from time of signing unless specified otherwise. Alternate expiration date: _____

(continues on next page)

Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA act of 1996.

_____	_____	_____
Date	Signature of patient or representative	Relationship to the patient

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

_____ HIV/AIDS Virus **_____ Mental Health/Psychiatric Disorders**

_____ Sexually Transmitted infections **_____ Drug, Alcohol Abuse/Treatment**

_____	_____	_____
Date	Signature of patient or representative	Relationship to the patient

***If you request your records to be sent via email, please provide the email address and sign the acknowledgement regarding security below:**

Email Address:_____

Electronic distribution of records (ROI) is covered under the HIPAA Final Rule section 164.524(c)(2)(ii).

I have requested my records be sent via unencrypted email. I acknowledge that there is some risk that the email may be intercepted during transmission and read by a third party. I acknowledge that Maniilaq Health Services has advised me of this risk and that Maniilaq Health Services is not responsible for unauthorized access during transmission. I further acknowledge that Maniilaq Health Services is not responsible for safeguarding my information once it has been delivered. By signing below I affirm that I still wish to receive my records via unencrypted email:

_____	_____	_____
Date	Signature of patient or representative	Relationship to the patient

For Facility Use:		
Date Received:	Date Information Released:	Chart #:
ROI Specialist:	Verification Method:	

Revised 1/2018, Reviewed 1/14/2020, 3/17/2021, 3/4/2022, 1/13/2023