Rainforest Recovery Center
BARTLETT REGIONAL HOSPITAL

3250 Hospital Drive
Juneau, AK 99801
Ph: 907-796-8690
Fax: 907-796-8692

Authorization for Release of Information

Patient Information:

Patient Name: _____ **Birth Date:** _____

Address, City, State, Zip Code: _____

I authorize Rainforest Recovery to (may select both boxes for information exchange):

Request information from ☐: Release information to ☐:

Name of Person or Facility: _____

Address, City, State, Zip Code: _____

Phone #: _____ **Fax #:** _____

I Authorize the release of information relating to (Please Initial):

Substance Use Disorder Information _____ Psychiatric Evaluation/Treatment _____

Information to be Released/Requested:				
Dates of Treatment	From:		To:	
Purpose of Information being Release/Requested	Further Treatment ☐	Legal Proceedings ☐	Insurance Claims ☐	Other (Specify):
Type of Information to be Disclosed **(Please Initial in each box for information to be disclosed)**	Psychiatric Evaluation	Progress Notes	Assessment	Labs
	Discharge Summary		Medication List	
Way Information is to be released **(Please Initial)**	Verbal	Fax	Mail	Patient Pick Up

Authorization Expires 90 days from date of signing unless specified: _____

- I understand that I have the right to revoke this authorization at any time by submitting a written revocation to BRH HIM Department. I understand the revocation does not apply to information that has already been released.
- I understand that I may refuse to sign this authorization and it will not affect my treatment at RRC.
- I consider a photocopy of this authorization to be valid as the original. I understand that upon request inspect information to be disclosed.
- I do not authorize further release to any third party. I understand that once information is release as specified in this authorization, RRC, their employees and physician(s) cannot prevent re-disclosure of the information. I hereby release RRC all liability arising directly or indirectly from disclosure authorized by this consent.
- I understand that my alcohol and/or drug treatment records are protected under 42 CFR, Part 2 and 45 CFR, parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided by regulations

My signature hereby authorizes Rainforest Recovery Center release/request information to the above:

_____

Patient/Responsible Party Relation Date