Rainforest Recovery Center
Bartlett Regional Hospital

3260 Hospital Drive
Juneau, Alaska 99801
Phone: 907-796-8296
Fax: 907-796-8497

Patient Information:

Patient Name: _____ Birth Date: _____ Medical Record #_____

Address: _____ City/State/Zip: _____

I Hereby Authorize Rainforest Recovery Center to RELEASE Information TO:

Name of Facility/ Organization/ Individual: _____

Address: _____

City/State/Zip: _____ Phone #: _____ Fax #: _____

I Hereby Authorize Rainforest Recovery Center to REQUEST Information FROM:

Name of Facility/ Organization/ Individual: _____

Address: _____

City/State/Zip: _____ Phone #: _____ Fax #: _____

Information to be RELEASE/REQUESTED:

1. Dates of Treatment: From _____ to _____
2. Purpose for information being RELEASED/REQUESTED (Please Initial):

   Further Treatment _____ Legal Proceedings _____ Insurance Claim _____ Other (specify): _____

3. Type of Information to be disclosed (Please Initial):

   Consultation _____ History & Physical _____ Progress Notes _____ Fax _____

   Verbal Exchange _____ Discharge Summary _____ Psychiatric Emergency Evaluation _____

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

Substance Use Disorder Information _____ Psychiatric Evaluation/Treatment _____

This Authorization Expires on the Following Date, Event or Condition (Please write in a date): _____

***If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from date of signing.**

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

Signature for Authorization to Release/Request Medical Information:

_____ _____ _____

Signature of Patient or Legally Responsible Party | Relationship to Patient | Date

For Office Use Only: ID Verified & Medical Records Released by: _____ Date: _____

MR#:_____ Date Records Mailed/Faxed/Picked Up: _____ Therapist Initials: _____