Bartlett Outpatient Psychiatric Services

3260 Hospital Drive, Juneau, Alaska 99801
Telephone (907) 796-8498 Fax: (907) 796-8497

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Patient Name: _____ Birth Date:_____ Medical Record # (if known)_____

Address: _____ City / State/ Zip: _____

I Hereby Authorize Bartlett Outpatient Psychiatric Services to Release Information TO:

Name of Facility/ Organization / Individual: **If you would like BOPS to release information, this line must match the FROM box below, meaning ROIs are for one facility, organization, or individual only.**

Address: _____

City / State / Zip: _____ Phone Number: _____ FAX: _____

I Hereby Authorize Bartlett Outpatient Psychiatric Services to REQUEST Information FROM:

Name of Facility/ Organization / Individual: **From whom are we requesting information? Ex. Valley Medical, Thunder Mountain High School, your spouse, etc.**

Address: _____

City / State / Zip: _____ Phone Number: _____ FAX: _____

- ❑ Dates of treatment: From **Specific date** To **Specific date, up to 1 year in future. For example, 9/15/2023.**
- ❑ Purpose or need for information being requested: **Please Initial At Least One Purpose Below**
  Further Treatment _____ Legal Proceedings _____ Insurance Claim _____ Other (specify): _____
- ❑ Type of Information to be used or disclosed: **Please Initial At Least One Type of Information to be Released**
  _____ Consultation _____ History & Physical _____ Progress Notes _____ Verbal Exchange
  _____ Discharge Summary _____ Psychiatric Emergency Evaluation _____ Fax

I authorize the release of information relating to: Please Initial if Applicable
_____Substance Use Disorder Information _____Psychiatric Evaluation / Treatment

This Authorization expires on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the 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 BOPS 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 BOPS.
** I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.
** I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, BOPS 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 CFR, parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

PATIENT AUTHORIZATION TO RELEASE 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: _____