Neurological Consultants of Alaska, LLC
Dr Wayne Downs □ Dr. Mary Downs
2741 DeBarr Road, Suite 413, Anchorage, AK 99508
Phone (907) 277-1623 - Fax (907) 277-1624

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ DOB: _____

I authorize: Neurological Consultants of Alaska, LLC To Release to Name: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Information to be used or disclosed:	☐ Entire record including, without limitation, personal health information and other records pertaining to treatment, payment or services sought or received, including non-medical services and the records listed below (if this box is checked, all boxes below are presumed to be checked) ☐ Admission/Intake Summary ☐ Health History/Physical Records ☐ Medication Records ☐ Psychosocial History ☐ Lab Reports ☐ HIV Status ☐ Treatment Plan ☐ Discharge Summary ☐ Immunization Records ☐ Educational Assessments ☐ Progress Notes ☐ Substance Abuse Treatment ☐ Psychological Evaluation ☐ Psychiatric Evaluation ☐ Other (specify below)
Purpose(s) for which health information may be used/disclosed	☐ At the request of the individual or representative ☐ Other (specify)_____
Authorization Expires On:	**If this is not completed, Authorization expires one year from date of signature.**

I understand that I have the right to revoke this authorization, except to the extent that it has already been relied upon or records have already been released. I may revoke this authorization by writing to the provider to whom this was provided. I understand that information disclosed under this Authorization may be redisclosed by the recipient. The federal privacy rules may not protect my health information once the recipient rediscloses my health information. I understand that I may decline to sign this authorization. I understand that covered entities may not refuse to treat me or otherwise condition benefits on signing this authorization, except that a provider may refuse to provide me with research-related treatment if I do not authorize use or disclosure of my health information for research purposes. Also, if the purpose of my treatment is solely to disclose health information to a third party, the provider may refuse my treatment if I do not agree to authorize disclosure of my health information to that third party. I understand that my alcohol and/or drug treatment records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA), and Federal Regulations relating to HIPAA, 45 CFR parts 160 and 164, and that, depending on the nature of the record and treatment involved, my records may also be protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2. I understand that health information released, if covered by 42 CFR Part 2 (alcohol and drug abuse records), will continue to be protected by law from redisclosure. However, if the information is covered only by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand that my records cannot be disclosed by covered entities beyond what is permitted under this authorization without my written consent, unless provided for by the regulations.

BY SIGNING , I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM

_____ _____
Signature (Authorized Representative) Date

_____
Description of Authorized Representative's authority to act for the patient: