Haines Assisted Living, Inc.

P.O. Box 916, Haines, Alaska 99827
Phone: (907) 766-3616 Fax: (907) 766-3617

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTHCARE INFORMATION

I, _____, hereby voluntarily authorize the disclosure of information from my record.

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	**Haines Assisted Living, Inc.**
ADDRESS	**P.O. Box 916**
CITY/STATE	**Haines, AK 99827**

The purpose or need for this disclosure is (e.g. assessment for assisted living): _____

The information to be disclosed from my health record is (check appropriate box(es)):

☐ Only information related to (specify): _____
☐ Only the period of events from _____ to _____
☐ All healthcare information
☐ Other (specify): _____
☐ Psychotherapy notes ONLY (by checking this box, I am waiving any psychotherapist/patient privilege)

To disclose any of the following sensitive information, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral
☐ Sexually Transmitted Diseases
☐ HIV/AIDS-related Treatment
☐ Mental Health (Other than Psychotherapy Notes)

I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event (*enter if different from one year after date below*): _____

I understand that HAL, Inc. will not condition treatment or eligibility for care on my providing this authorization except if such care is (1) research related or (2) provided solely for the purpose of creating Protected Health Information for the disclosure to a third party.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164]. And the Privacy Act of 1974 [5 USC 552a]

SIGNATURE OF PATIENT	DATE OF BIRTH	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	RELATIONSHIP	DATE

Revised 7/3/09

EQUAL HOUSING OPPORTUNITY