

# FRONTIER HEALTH AND WELLNESS, LLC



## Authorization to Obtain and Disclose Healthcare Information

This release is written on behalf of Frontier Health and Wellness and its Contracted Providers (listed below)

Frontier Health Services, P.C.- Dr. E. David Hjellen  
Alpine Assessments, LLC - Erin Johnson, Ph.D.

Beyond Barriers Counseling - Victoria Swatek, LPC, CATP  
Woods Neuropsychological Services, LLC - Rachel Woods, Ph.D.

Olivia Harris, LLC - Olivia Harris, PMHNP  
Tina DeMure LLC - Tina DeMure, PMHNP

**This Release applies to both medical health information and mental health information**

### Patient Identification:

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Client Previous Name (if applicable): \_\_\_\_\_

Name of Parent/Guardian (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Home Number \_\_\_\_\_ Work Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### Release To/From:

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Name: Frontier Health and Wellness, LLC and its contracted providers Phone: 907-222-6606

### Release To/From:

Address: 4241 B Street Suite 305, Anchorage, Alaska 99503 Fax: 855-719-0457

### Purpose of the Request:

Personal (at the request of the client)  Treatment  Legal  Insurance  Government

Other (specify): \_\_\_\_\_

### Information Authorized For Release:

Any Conditions/Diagnosis/Event/Time Frame Limits:  Yes  No

Specific limits (if checked Yes): \_\_\_\_\_

### *Please check the type of information to be released:*

<input type="checkbox"/> Intake Evals (History & Physicals)	<input type="checkbox"/> Progress Notes (Last 5)	<input type="checkbox"/> Diagnosis/Procedure Note
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes (All)	<input type="checkbox"/> Photographs, Videotapes
<input type="checkbox"/> Mental Health Evaluations	<input type="checkbox"/> Medication Sheets (historical)	<input type="checkbox"/> Emergency Dept. Reports
<input type="checkbox"/> Neuropsychological Testing Reports	<input type="checkbox"/> Medication Sheets (current list)	<input type="checkbox"/> Radiology Films/Images/Reports
<input type="checkbox"/> Social Worker/Nursing Assessments	<input type="checkbox"/> Verbal Exchange of Information	<input type="checkbox"/> Billing/Financial Information/Statements
<input type="checkbox"/> Laboratory Test/EKG Results	<input type="checkbox"/> Education Reports	<input type="checkbox"/> Complete Health Record
<input type="checkbox"/> Other, (specify) _____		

Receive by:  Mail  Fax  Pick-up  Oral Exchange

### Not Obligated

This confirms that I am not signing this form under duress and am not obligated to sign this form to receive treatment. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information.

### Expiration & Right to Revoke Consent

I understand that any time I may revoke this authorization by submitting a notice in writing to any provider listed on this form. Unless revoked earlier, this authorization will expire twelve months from the date on which it was signed, or upon the following

**This Release Will Expire On:** \_\_\_\_\_

### Re-Disclosure

I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by legal representative/guardian, relationship to patient: \_\_\_\_\_