FRONTIER HEALTH AND WELLNESS

Authorization to Obtain and Disclose Healthcare Information

This release is written on behalf of Frontier Health and Wellness and its contracted providers

FHW Contracted Providers: Frontier Health Services - Dr. E David Hjellen,
Beyond Barriers Counseling - Victoria Hutton, LPC
Bore Tide Behavioral Health - Kelly Moore, APRN
Tina DeMure LLC - Tina DeMure, APRN

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: _____

Release To/From: Name: _____ Phone: _____

Address: _____ **Fax:** _____

Release To/From: Name: Frontier Health and Wellness and its contracted providers Phone: 907-222-6606

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/Timeframe Limits: ☑ No ☐ Yes

Specific limits (if checked Yes): _____

Please check the type of information to be released:

☐ Intake Evals (History & Physicals)	☐ Progress Notes (Last 5)	☐ Diagnosis/Procedure Note
☐ Discharge Summary	☐ Progress Notes (All)	☐ Photographs, Videotapes
☑ Mental Health Evaluations	☐ Medication Sheets (historical)	☐ Emergency Dept. Reports
☑ Neuropsychological Testing Reports	☐ Medication Sheets (current list)	☑ 504 Plan
☐ Social Worker/Nursing Assessments	☑ Verbal Exchange of Information	☑ Individual Education Plan
☐ Laboratory Test/EKG Results	☑ Education Reports	☐ Complete Health Record

☐ 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 **date or event**: _____

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: _____

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* School Records