FRONTIER HEALTH AND WELLNESS

Authorization to Obtain and Disclose Healthcare Information for Neuropsychological Testing

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

FHW Contracted Providers: Erin Johnson, Ph.D., Alpine Assessments, LLC
Rachel Woods, Ph.D., Woods Neuropsychological Services, LLC

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: 855-595-2950

Purpose of the Request is for Diagnostic Testing

Information Authorized For Release:

PLEASE RELEASE THE FOLLOWING RECORDS/INFORMATION

- Intake Note/Assessment
- Diagnosis List (past and present)
- Medication List (past and present)
- Treatment plan
- Discharge Note/Summary
- Other _____

Receive by: ☐ **Mail** ☑ **Fax**

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: _____