

# 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
- Last 2 Progress Notes
- Diagnosis List (past and present)
- Discharge Note/Summary
- Treatment Plan
- 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: \_\_\_\_\_