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.
SRA D.O., LLC - Dr. Spencer Augustin

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: _____

Release To/From:

Name: _____ Phone: _____

Address: _____ Fax: _____

Release To/From:

Name: Frontier Health and Wellness, LLC 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/Time Frame Limits: ☐ Yes ☐ No

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)	☐ Radiology Films/Images/Reports
☐ Social Worker/Nursing Assessments	☐ Verbal Exchange of Information	☐ Billing/Financial Information/Statements
☐ 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

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: _____