ALYESKA
Therapy Center, Inc.

HIPPA Authorization for Release of Information

I _____ authorize Alyeska Therapy Center, Inc. to use and disclose the protected health care information described below to/from the following facilities/individuals.

Please specify name and address of facility or individual.

_____

_____

This authorization for release of information covers the period of health care from:

☐ A) _____ to: _____

☐ B) All past, present and future periods.

I authorize the release of my complete health records to/from Alyeska Therapy Center, Inc. including records relating to the following:

☐ HIV or AIDS ☐Communicable Diseases

☐ Treatment of Alcohol or Drug Abuse ☐Mental Healthcare

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.

This authorization shall be in force and effective until _____ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed name of patient or personal representative Relationship to patient