



**ALASKA CHILDREN'S SERVICES
AUTHORIZATION FOR EXCHANGE OF INFORMATION**

I hereby authorize Alaska Children's Services to exchange personal health information between Alaska Children's Services

And: Name: _____ Fax: _____

Address: _____

For: Student Name: _____ Date of birth: _____

PLEASE RETURN FORM TO: ATTENTION: _____

**Alaska Children's Services: 4600 Abbott Road Anchorage, AK 99507
(PH) (907) 346-2101 (FAX) (907) 348-9230**

INFORMATION TO BE RELEASED/REQUESTED FOR THE FOLLOWING PURPOSE:

Treatment Legal Request Insurance Claim Other: _____

Please check specific information to be released:

<input type="checkbox"/> Biopsychosocial Summary	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> School Records(transcripts, disciplinary reports, IEP, other plans)
<input type="checkbox"/> Consultations	<input type="checkbox"/> Medical History/Physical Exam	
<input type="checkbox"/> Neuropsychological Assessment	<input type="checkbox"/> Medical and Laboratory Results	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Psychological Assessment(s)	<input type="checkbox"/> UA Results	<input type="checkbox"/> Special Education Records
<input type="checkbox"/> Treatment Plan and Review(s)	<input type="checkbox"/> Medical/Dental Aftercare Plan	
<input type="checkbox"/> Intake /Mental Health Assessment	<input type="checkbox"/> Verbal exchange of all information to aid in assessing and/or treating student	
<input type="checkbox"/> Psychiatric Assessment	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Substance Abuse Assessments	<input type="checkbox"/> Discharge/Continuing Care Summary	

This information may be used for continuation of care. I understand this authorization will expire on: _____ and/or **6 months following the date of discharge from any ALAKSA CHILDREN'S SERVICES PROGRAM**, revocation of custody or guardianship, or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photo static and/or facsimile copies of this authorization will be considered as valid as the original.

PROHIBITION ON REDISCLOSURE: *This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations restrict any use of this information to investigate or prosecute any alcohol or drug abuse patient. Disclosure of patient information is permitted with the patient's written consent: however, disclosures to central registries and in connection with criminal justice referrals must meet the following specific regulations: (42 CFR 2.32 and 2.33). This information disseminated from Alaska Children's Services.*

I acknowledge that the information to be released is protected by Federal law and may include information regarding drug/alcohol abuse, sexually transmitted diseases/HIV and/or Hepatitis B. My signature below authorizes the release of this information. I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. 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.

Student: _____

Date: _____

Parent/Guardian: _____

Date: _____

Witness: _____

Date: _____