AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____ Social Security No.:_____

To: All my health care providers, specifically including the following:_____
_____

Pursuant to Alaska Civil Rule 26(b) and for use only in divorce, custody, paternity or modification litigation, I,_____, hereby consent and authorize those who have custody of or knowledge concerning my medical and health information and treatment to release, copy and discuss the information described below with the following persons:

- ☐ my attorney and staff_____
- ☐ the opposing party _____
- ☐ the opposing party's attorney and staff _____
- ☐ other _____

I understand that this authorization is voluntary, though refusal to authorize the release of medical and health information and treatment may affect a court's actions. I understand that if the organization authorized to receive the information is not a health plan or health care provider, federal privacy regulations may no longer protect the released information.

This authorization includes the contents of my chart and file including, but not limited to, all x-rays, slides, laboratory requests, test results, patient charts, hospital records, psychiatric, psychology and counseling records, physical therapy records, reports and notes from physicians and nurses, correspondence, memoranda, prescriptions and billing statements.

Initials: _____ **I understand this Release includes all information related to alcohol, drug abuse, psychological/psychiatric, STD or HIV/AIDS diagnosis or treatment.**

Initials: _____ I understand that this authorization will expire at the conclusion of the court case entitled _____ or expire on _____, 20___, if earlier.

Initials: _____ I understand that I may revoke this authorization by notifying the above provider in writing. Revocation will not affect information already released.

Initials: _____ I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

Initials: _____ I understand the released information may no longer be protected by federal privacy regulations and may be redisclosed.

I do not authorize the disclosure of any information about me beyond that described above without my or my attorney's express consent. A photocopy of this Release is effective and valid as the original.

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ***

_____ _____
Date *Signature of Person Releasing Information*

Relationship to patient if patient is a minor: ☐ Mother ☐ Father ☐ Guardian

The foregoing instrument was acknowledged before me on _____, 20___, by the person named above.

(SEAL)

_____
Notary Public in and for _____
My commission expires: