ALASKACARE Health Plans

Authorization for the Use and/or Disclosure of Protected Health Information (PHI)

FOR OFFICE USE ONLY

Toll-Free: (800) 821-2251
alaska.gov/drb

Division of Retirement and Benefits
P.O. Box 110203
Juneau, Alaska 99811-0203

Juneau: (907) 465-4460
TDD: (907) 465-2805
Fax: (907) 465-3086

MEMBER INFORMATION

Last Name		First Name	Middle Initial
Health Plan ID Number	Birthday (MM/DD/YYYY)	Daytime Telephone number (include area code) ( )	
What is the patient's relationship to the member? ☐ Self ☐ Spouse ☐ Child ☐ Other:			

PATIENT INFORMATION

Last Name		First Name	Middle Initial
Health Plan ID Number	Birthday (MM/DD/YYYY)	Daytime Telephone number (include area code) ( )	

AUTHORIZED PERSON(S) OR ENTITY(S) TO WHOM ALASKACARE MAY RELEASE YOUR PHI

Person or entity authorized to receive PHI	Daytime Telephone number (include area code) ( )
Street Address	City, State and Zip
Person or entity authorized to receive PHI	Daytime Telephone number (include area code) ( )
Street Address	City, State and Zip
Person or entity authorized to receive PHI	Daytime Telephone number (include area code) ( )
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PLAN NAME	NATURE OF PHI
☐ Medical	☐ Benefits, enrollment, premiums and eligibility
☐ Dental	☐ Claim
☐ Vision	☐ Health Appeal
☐ Health Flexible Spending Account	☐ Medical/Treatment/Diagnostic Records
☐ Other: (please specify)_____	☐ Other: (please specify)_____

REASON FOR USE AND/OR DISCLOSURE

The health information described above in Nature of PHI may be used only for the purpose(s) indicated here.

☐ To resolve a benefits claim for the patient listed above for:
Date(s) of service: _____

Name of Provider(s): _____
_____
_____

☐ To resolve an issue regarding the enrollment and coverage of:
☐ Myself
☐ My family member(s): _____

☐ To obtain claims or other information in order to assist me or a family member in dealing with another insurance company.

☐ At the request of the individual (check this box if individual does not want to disclose reason for request).

☐ Other: _____

IMPORTANT: Your signature below means that you understand and agree to the following:

- This authorization expires on: _____
(An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. If no expiration date is listed, this authorization will expire two (2) years from the date of signature.)
- The phrase "medical records" as used in Nature of PHI includes but is not limited to physical health, mental health, treatment for alcohol and/or drug abuse, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV).
- I understand that, if the person or entity I have authorized on this form to receive my PHI is not required to comply with federal privacy protection regulations, my health information may be further disclosed and is no longer protected.
- I understand that I may revoke this authorization at any time by notifying the Plan in writing at the address on the front of this form. I also understand that my revocation cannot affect any use and/or disclosure of protected health information based on this authorization if it occurred before the Plan received my revocation letter.
- I understand that my eligibility for benefits and payment for services will not be affected if I do not sign this form. I also understand that without my signature, my request to release the information described above to a third party will not be honored.
- You should retain a copy of this form for your records. You may also request a copy by writing to the address listed on the front of this form.
- If we receive requests for copies of claims and other information from the individual or company you have authorized to receive your confidential information, we may charge a reasonable fee (except where prohibited by law) for copying and mailing costs.

I authorize AlaskaCare to release my PHI as indicated on this form to the person(s) or entity(s) identified.

Signature of Patient or Legal Representative of Patient	Date
Print Name	**Daytime Telephone number (include area code)**
	( )

Must be signed by the person whose records are to be released, unless that person is under the age of 18 and is not emancipated.

If not the Patient, describe relationship to the Patient:

☐ Natural or Adoptive Parent of Unemancipated Minor Child

☐ Other Legal Representative (You must furnish a copy of the healthcare power of attorney or other legal document(s) designating you as the legal representative.)

☐ Relationship to the patient, including authority for status as legal representative