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, PC	SRA, D.O., LLC	Olivia Harris, LLC	Beyond Barriers Counseling
Dr. E David Hjellen	Dr. Spencer Augustin	Olivia Harris, PMHNP	Victoria Swatek, LCP, CATP

This Release applies to medical, psychiatric/mental health and educational information.

Patient Identification

Patient Name:____**Date of Birth:**____________________________

Patient Previous Name(s), if applicable:____

Name of Parent/Legal Guardian, if applicable:____

Patient Address: ____

Patient Phone Number:____

Release To/From

Name: ____**Phone:**______________________

Address: ____**Fax:**________________________

Release To/From

Name: Frontier Health and Wellness, LLC Contracted Providers **Phone:** 907-222-6606

Address: 3201C Street, Suite 606 Anchorage, Alaska 99503 **Fax:** 855-719-0457

This request is for the purpose of treatment and/or continuity of care. If this request is for any other purpose, please check or describe below.

Personal Work/FMLA Legal Insurance Government

Other:____

Information Authorized to Be Released

If there are any condition/diagnosis/event/time frame limits, please list here:______________________________________

Specific 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): ____

All records will be sent via fax (or USPS if fax is unavailable) unless otherwise specified here: ______________________________

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, and/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:____________________________________