Authorization for Release of Information

1.) I, _____D.O.B._____ S.S.#_____

Hereby authorize:

Division of Senior and Disability Services

To Exchange with:

Challenge Alaska Inc.
3350 Commercial Drive, Suite 208
Anchorage, AK 99501
(907) 344-7399

1.) The following Specific Information:
( ) History & Physical
( ) Vocational Plan
( ) Psychological Evaluation
( ) Social History
( ) Other: Any pertinent Clinical information regarding TX and Planning for the Specific illness or injury of: _____

I understand specific references may be made to psychiatric and physical conditions, HIV testing and results, and any related diagnosis and medical condition(s) which may be recorded in my health record. I hereby authorize the release of any medical condition or related information. Exchange of information ensures continuity of care between providers. By not sharing information, my health care could be compromised. Only that information which I authorize will be released.

2.) The purpose of this released information is: Continuity of care
I understand that the information released/exchanged will be treated in a confidential manner and will not be released to other persons or agencies without my specific authorization. This authorization expires one year from the date of signature. I understand I have the right to revoke this consent at any time in writing except to the extent that the information has already been released.

Signature of Witness: _____ Date: _____

Signature of Patient/client: _____ Date: _____