Holly DiMeglio, ANP, RN

Pediatric Nurse Practitioner
Office 907.644.3968 Fax 907.644.3969

8717 Dimond D Circle
Anchorage, Alaska 99515

AUTHORIZATION OF RELEASE OF CONFIDENTIAL INFORMATION

CLIENTS NAME:_____Date of Birth:_____

Social Security Number:_____Chart Number:_____

Requesting Entity: **Holly S DiMeglio, ANP, RN**	Releasing Entity:_____
8717 Dimond D Circle Street Address	_____ Street Address
Anchorage, Alaska 99515 City / State / Zip	_____ City / State / Zip
907-644-3969 / 907-644-3968 Fax Phone	_____ / _____ Fax Phone

_____ (initial) I authorize this release to be reciprocal between the two parties.

INFORMATION AUTHORIZED FOR RELEASE

____ ☐ Psychological Evaluations/Reports	____ ☐ Social History
____ ☐ Psychiatric Evaluations/Reports	____ ☐ School/Vocational/ Work Information
____ ☐ Physical / Medical Records	____ ☐ Discharge Summary (ies)
____ ☐ Lab Results	____ ☐ Verbal Information
____ ☐ Radiology Reports (CT/MRI)	____ ☐ Any documents which may include

I hereby authorize the above information to be released to the party I have indication for the purpose of:
_____continuity of care _____ other:_____
I retain the right to revoke this authorization in writing prior to the expiration date below.

Treatment may not be conditioned on obtaining the authorization if that is prohibited by the HIPPA Privacy Rule. The information disclosed pursuant to this authorization may be subject to re-disclosure by the designated recipient, and subsequently no longer protected by the HIPAA Privacy Rule.

_____ *Signature of Client or Client's Designee*	_____ *Designee's Relationship to Client*
_____ *Witness*	_____ *TO* _____ *Date Authorized* *Date Authorization ends*

Send out ** **Keep in File ****