Holly DiMeglio, ANP, RN

Pediatric Nurse Practitioner

1407 West 31st Avenue, Suite 201
Anchorage, Alaska 99503

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:___________________________

___1407 W 31st Ave Suite 201b________________ ______________________________________
Street Address Street Address

________Anchorage, Alaska 99503_____________ ______________________________________
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
- ☐ Psychiatric Evaluations/Reports
- ☐ Physical / Medical Records
- ☐ Lab Results
- ☐ Radiology Reports (CT/MRI)
- ☐ Emergency Reports
- ☐ Social History
- ☐ School/Vocational/ Work Information
- ☐ Discharge Summary (ies)
- ☐ Verbal Information
- ☐ Any documents which may include information regarding **HIV status**.
- ☐ Any documents which may include information regarding **chemical dependency.**

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*

_______________________________ _______________ *TO* _______________
Witness *Date Authorized* *Date Authorization ends*