Authorization to Release Records or Information

I AUTHORIZE: Release To: ☐ Obtain From: ☐ **Please Initial**

MAT-SU HEALTH SERVICES, INC.
1363 W. Spruce Ave.
Wasilla, Alaska 99654
PH: 907-376-2411
Fax: 907-352-3373
Email: records@mshsak.org

Name of Person or Agency _____

Street Address _____

City **State** **Zip Code** _____

PH: **Fax:** _____

Requested Dates: Most Recent ☐ Last 6 months ☐ Last Year ☐ Other ☐ _____

*** INITIAL below all that apply:**

_____**Discharge Summary**	_____ **Therapy Notes**	_____**Office Visit**
_____**Intake Assessment**	_____ **Therapy Notes: SUD***	_____**Labs**
_____**SUD Assessment***	_____**Case Management**	_____**Labs: SUD***
_____**Psychiatric Evaluation**	_____**Community Based Services**	_____**Medications**
_____**Treatment Plan**	_____**Office Visits: Psychiatric**	_____**Medications: SUD***
_____**Verbal**	_____**Dental/Radiographs**	_____**Imaging**
_____**Other:** _____		**SUD: Substance Use Disorder*

Receive by: Mail ____ Fax ____ Pick Up ____ Verbal ____ Electronic_____
Purpose of the Request: Treatment _____ Legal _____ Insurance _____ Personal _____ Other_____

**I understand that information in the Health Record may contain information relating to mental health or behavioral health, alcohol and drug abuse, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).*
**I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.*
**I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.*
**I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.*
**I understand I have the right to receive a copy of this authorization form. I also understand that upon my written request, MSHS must provide me a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes.*

Client Name (Please Print) _____
Date of Birth: _____ Phone Number: _____
Client Signature: _____ Date: _____
(Minor's signature is required with regards to drug and alcohol information)
Parent/Guardian: _____ Date: _____
Witness: _____ Date: _____
This authorization will terminate one year from the date signed, or unless an earlier date or condition / event is specified here:

_____

Recipient Information: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose.
This authorization is revoked: _____ Date: _____

Service Provider to Complete
__ Send for Records __ Send Authorization
__ Release MSHS Records __ File Authorization

For Office Use Only

07/2025 - CMK

A FAXED COPY OF THIS RELEASE SHALL BE CONSIDERED AS ORIGINAL

MAT-SU HEALTH SERVICES, INC.
1363 W. Spruce Ave., Wasilla, AK 99654
Ph: (907) 376-2411 Fax: (907) 352-3373

FEE SCHEDULE FOR COPIES OF CLIENT RECORDS

The following fee schedule shall be used in accordance with the Release of Information Policy when providing copies of client charts to authorized individuals/agencies:

PAPER COPIES:

Lawyers and insurance request:
- $10.00 – for the first ten (10) pages
- $ 0.25 – per each additional page

For client, parent or guardian copy of records:
- $5.00 – for the first ten (10) pages
- $0.25 – for each additional page

For federally – or state- reimbursable agencies, such as Division of Vocational Rehabilitation (DVR) or Disability Determination Unit (DDU) of the Social Security Administration, which are authorized to reimburse for copies of client charts:
- $15.00 – flat fee per request

For other human services providers, such as other mental health agencies, doctors' offices, hospitals, Public Assistance, etc.:
- $0.00 – no charge – provided as a courtesy for ongoing client care

ELECTRONIC COPIES: ***Additional fees will be charged if a jump drive is needed***

For attorneys and insurance requests:
- $25.00 – for the first year of records
- $10.00 – Each additional year of records
- $55.00 – Maximum

For client, parent or guardian copy of records:
- $5.00 – initial fee for the first year, each additional year is $5.00 not to exceed $25.00

For other human services providers, such as other mental health agencies, doctors' offices, hospitals, Public Assistance, etc.:
- $0.00 – no charge – provided as a courtesy for ongoing client care

The HIPAA Privacy Rule permits the covered entity (Mat-Su Health Services, Inc.) to impose reasonable, cost-based fees. The fee may include only the cost of copying (including supplies and labor) and postage, if the client requests that the copy be mailed. If the client has agreed to receive a summary or explanation of his or her protected health information, the covered entity may also charge a fee for preparation of the summary or explanation. The fee may not include costs associated with searching for and retrieving the requested information. See 45 CRF 164.524.