Family Centered Services of Alaska
Authorization to Inspect or Copy Client Record

Client #:	**Client Name:**
I hereby authorize_____ to Release Information to **Person/Agency:**	
Address:	
City/State/Zip:	
Phone:	**Fax:**

Information Requested:

☐ **Psychological Assessments**	☐ **Treatment Plan/Reviews**
☐ **Clinical Progress Notes**	☐ **Treatment Team Meeting Notes**
☐ **Discharge Summary**	☐ **Application for Services**
☐ **Inspect File**	☐ **Other:**

This protected health information is being used or disclosed for the following purposes:

_____

[List specific purposes. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose.

This authorization is good through ___/___/____ (maximum of one year) and is given voluntary in writing for the above stated purpose. I have read this form and/or I have had it read to me and explained in a language that I can understand. This authorization will remain in effect until the expiration date unless it is revoked earlier. This authorization can be revoked at any time, by contacting the FCSA Privacy Officer and completing the withdraw authorization section below; this will not change any action taken between the original authorization date and date of revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state regulations.

Client Signature:	**Print Name:**	**Date**
Parent/Legal Guardian:	**Print Name:**	**Date**
Witness:	**Print Name:**	**Date**

I withdraw my authorization for persons/agencies to share information as listed on this Authorization

_____ _____

Signature of Parent/Legal Guardian Date Signed

12-7-05