PsychRights®
Law Project for
Psychiatric Rights, Inc.

AUTHORIZATION FOR RELEASE OF INFORMATION

(By Parent or Guardian)

To: All Treating Medical Personnel and their Employers, Alaska Department of Health and Social Services, Alaska Office of Children's Services, Alaska Division of Juvenile Justice, Alaska Psychiatric Institute, Alaska Division of Behavioral Health and Alaska Division of Health Care Services.

I, _____, the _____ of _____ _____, born _____, Social Security Number_____, to the extent of my authority, hereby authorize and direct you to:

(1) communicate with the Law Project for Psychiatric Rights (PsychRights®),
(2) answer all of PsychRights' questions, and
(3) provide copies of all documents and other materials requested by PsychRights pertaining to_____.

The purpose of this consent is to enable PsychRights to acquire information in connection with its prosecution of *Law Project for Psychiatric Rights v. State of Alaska et al.*, 3AN 08-10115CI, Alaska Superior Court, Third Judicial District, State of Alaska. This authorization encompasses all information that is relevant or may lead to relevant information in the lawsuit as determined by PsychRights, including, but not limited to:

(i) medical and mental health treatment, including the administration of psychotropic medication,
(ii) diagnoses and indications,
(iii) medical necessity,
(iv) informed consent,
(v) monitoring for negative effects of treatment,
(vi) communications with individuals and agencies,
(vii) consideration of psychosocial interventions, and
(viii) monitoring the level and type(s) of improvement or deterioration in behavior, life skills, family, school, and social relationships, sports, and the ability to cope with life's demands.

I understand that:

(a) The records are protected under federal confidentiality regulations issued under the Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed without written consent unless otherwise provided for in the regulations.
(b) The released records may contain sensitive information.
(c) PsychRights is not a covered entity under HIPAA and the information being disclosed may be subject to redisclosure, including use in the court case, and may otherwise no longer be protected under the regulations.
(d) I may revoke this consent by notifying PsychRights.
(e) This consent expires at the earlier of _____, or the conclusion of the lawsuit if the blank is left empty.

A copy hereof, shall be effective.

Executed this ____ day of _____, 2009.

_____
[Signature]

_____
[print name]

406 G Street, Suite 206, Anchorage, Alaska 99501 ~ (907) 274-7686 Phone ~ (907) 274-9493 Fax
http://psychrights.org

Contact Information:

Name: _____
[Printed]

Phone: _____

E-mail: _____

Address: _____

_____

Provider(s) (such as Northstar):

_____

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Prescribing Psychiatrist(s) or Other Physician(s):

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Prescribing Nurse Practitioner(s)

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