KODIAK COMMUNITY HEALTH CENTER

MRN_____
1911 East Rezanof Drive
Kodiak, AK 99615
Phone: (907) 481-5000
Fax: (907) 481-5030

Authorization for Release of Information

Please allow 7 to 10 business days for requests to be processed.

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Social Security #: _____

Release Records FROM:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Release Records TO:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Information to Release:

_____ Complete Medical Record (Last 2 Years)
_____ Colonoscopy (Last 10 Years)
_____ Pap Smear (Last 5 Years)
_____ Mammogram (Last 2 Years)
_____ Complete Immunization Record
_____ Progress Notes
_____ Laboratory Reports
_____ Radiology Reports
_____ Medication List
_____ Physical Form(s)
_____ Dental Records
_____ Other (Specify Below)
_____
Dates of Service: _____To: _____

Method of Release: _____ Pick-Up _____ Fax _____ Mail _____ Verbal _____ Email: _____

If you would like any of the following sensitive information disclosed, you must check the applicable below and sign:

_____ Alcohol/Drug Abuse Treatment
_____ Mental/Behavioral Health
_____ Sexually Transmitted Diseases
_____ HIV/AIDS

I understand that the information in my health record may contain information regarding the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, and mental/behavioral health.

_____ _____
Patient Signature/Legal Guardian Date

- I understand that once this information is disclosed, the information is subject to re-discourse and may no longer be protected by the Federal Privacy Regulations.
- I understand that I have a right to revoke the authorization **IN WRITING** to KCHC at any time. I understand that the revocation will not apply to information that has already been released by this authorization.
- I understand that this authorization will automatically expire 12 months from the date signed or earlier if revoked by me in writing.

_____ _____
Signature of Patient, Parent or Legal Representative Date

_____ _____
Print Name Relationship to Patient

_____ _____
Witness Date

FOR OFFICE USE ONLY Received By: Date: Request Completed By: Date:
Requesting Provider: