KODIAK COMMUNITY HEALTH CENTER

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

Authorization for Release of Health Information

Patient Name: _____ DOB: _____

Last Four Digits of Social Security #: _____ Telephone: _____

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

PLEASE CHOOSE ONLY ONE PER FORM

- I authorize the Kodiak Community Health Center to _____ **RELEASE** copies of information from my medical records to:
- I authorize the Kodiak Community Health Center to _____ **RECEIVE** copies of my medical from:
- I authorize the Kodiak Community Health Center to _____ **DISCUSS** my medical condition with:

SEND TO/RECEIVE FROM:_____
PHONE NUMBER:_____ FAX NUMBER:_____
ADDRESS_____CITY_____STATE_____ZIP CODE:_____

Please check information to be requested/released:

- ☐ Progress Notes
- ☐ Lab Reports
- ☐ Immunization Record
- ☐ Radiology Reports
- ☐ Medication List
- ☐ Dental Records
- ☐ Other:_____

Release information by:

- ☐ Pick-up
- ☐ Verbal
- ☐ Mail
- ☐ Fax
- ☐ E-Mail (Provide E-Mail Address Below)

_____

DATES OF SERVICE FROM:_____ TO:_____

I understand that my records may be protected under Federal Confidentiality Regulations and cannot be disclosed without my signed consent unless as otherwise provided in the aforementioned regulation. I give special permission to release any information regarding **(check and sign on line(s) below that you grant KCHC permission to release the information to the above)**.

_____ Substance Abuse: Signature_____
_____ Mental/Behavioral Health: Signature_____
_____ HIV/AIDS: Signature_____
_____ STD: Signature_____

Please allow 3 to 7 business days for record requests to be processed.

- 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 the Health Information Department 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 Guardian Date

_____ _____
Print Name Relationship to Patient

_____ _____
Witness Date

FOR OFFICE USE ONLY Accepted By: Date Request Completed: Completed By: