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: _____

As the ☐ Patient ☐ Parent ☐ Legal Guardian, I hereby authorize Kodiak Community Health Center to:

☐ **Obtain Information FROM:** ***OR*** ☐ **Release Information TO:** **PLEASE CHOOSE ONLY ONE PER FORM**

Name/Organization: _____

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

Telephone: _____ Fax: _____

Please check information to be requested/released:

☐ Complete Medical Record
☐ Most Recent History (Past Year)
☐ Lab Reports
☐ Radiology Reports
☐ Immunization Record
☐ Medication List
☐ Complete Dental Record
☐ Other (Specify Below)

RELEASE information by:

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

_____ _____

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

- I understand that the information in my health record may include information related to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), if any. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand these records are protected under Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, Part2, and Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR Parts 160 and 164, and cannot be re-disclosed without written consent unless otherwise provided in the regulations.
- I understand authorizing the use or disclosure of the information is identified above is voluntary. I need not sign this to ensure healthcare treatment.
- I understand that I have a right to revoke this authorization in writing to Medical Records Department at any time. I understand that the revocation will not apply to information that has already been released to this authorization.

Unless revoked earlier, this authorization will expire one (1) year from date of signature. I hereby authorize the above use and disclosure:

_____ _____
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: