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) _____ Progress Notes _____ Dental Records
_____ Colonoscopy (Last 10 Years) _____ Laboratory Reports _____ Other (Specify Below)
_____ Pap Smear (Last 5 Years) _____ Radiology Reports ____________________
_____ Mammogram (Last 2 Years) _____ Medication List
_____ Complete Immunization Record _____ Physical Form(s) 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 ______Reproductive Health
_____ Sexually Transmitted Diseases _____ HIV/AID

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: