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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_ Telephone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please select *To/From* Please select *To/From***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Release: |  | From |  | To | Release: |  | From |  To (please list) |

|  |  |  |
| --- | --- | --- |
| *Homer Medical Center* |  Full Name:  |  |
| *Requesting Provider\_\_\_\_\_\_\_\_\_* | Organization: |  |
| *4136 Bartlett St* | Address: |  |
| *Homer, Alaska 99603* | City, State, Zip |  |
| *(ph) 907.235.8586* | Phone: |  |
| *(fax) 907.235.6639* | Fax: |  |

**Information requested *(REQUIRED: please check all that apply)*:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **Current Physical** |  | **Medication Lists** |  | **Labs/test results** |
|  |  | **X-ray/Diagnostic reports** |  | **ER/Hospital Records** |  | **Consults** |
|  |  | **Behavioral Health reports** |  | **Complete records** |  | **Dates:** |
|  |  |  |  |  |  |  |
| **Purpose of the Request *(REQUIRED: please check one)*:** |
|  |  | **Patient Request** |  | **Continuation of Care** |  | **Termination of care** |
|  |  | **Insurance Request** |  | **Open Communication** |  | **Other:** |
|  |  |  |  |  |  |  |

**Please initial:** I authorize the release of my STD results, HIV / AIDS testing, whether negative or

positive, to the person(s) listed above. I understand that the person(s) listed above will

**\_\_\_YES \_\_\_NO** be notified that I must give specific written permission before disclosure of these test results to anyone.

*Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq. includes herpes, herpes simplex human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.*

**\_\_\_YES \_\_\_NO** I authorize the release of any records regarding drug, alcohol, and psychiatric or mental health treatment to the person(s) listed above.

**\_\_\_YES \_\_\_NO** I hereby authorize the use or disclosure of my individual identifiable health information as described above. I understand that this authorization is voluntary. I consider a copy of this authorization to be as valid as the original. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. I understand that I may see and obtain a copy of the information described on this form if I ask for it and that I may get a copy of this form after I sign it. I understand that a fee for copies may be imposed by the person(s)/organization(s) listed above or by its designated business associate. I understand that the first complete records request will be provided free of charge once every 12months. All subsequent requests within a 12-month period will incur additional fees.

**\_\_\_YES \_\_\_NO** I understand that I may revoke this authorization at any time by notifying HMC in writing, and it will be effective on the date the notification is received, except to the extent action has already been taken prior to receiving it.

|  |  |  |  |
| --- | --- | --- | --- |
|  Signature: |  | Date Signed: |  |
| Print Name: |  |  Parent Legal Guardian Patient |

**THIS AUTHORIZATION EXPIRES 1 (ONE) YEAR AFTER IT IS SIGNED.**