Ilanka Community Health Center
705 Second Street – PO Box 2290
Cordova, AK 99574
Ph: 907-424-3622 Fax: 907-424-3275

Patient Name _____
Date of Birth _____
Contact Phone _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize _____, it's authorized employees or agents, to RELEASE information from my health record and speak with relevant persons concerning this information.

SEND RECORDS TO: Name _____ Phone/Fax Number _____
Address _____

Releases may take up to 72 business hours to process and are either faxed or mailed based on the number of documents. Please allow up to 7 business days for larger requests to process.

Record Information from these dates of service: From: _____ To: _____

Specific Information to be released:
□ Chart Notes
□ Imaging Report(s)
□ Pathology Report(s) (Biopsies, etc)
□ Laboratory Report(s)
□ All
□ Authorization
□ Other (Specify): _____

Please initial each record type you are authorizing to be released.

_____ **ALCOHOL or DRUG ABUSE RECORDS.**

I DO release the disclosure of any information relating to the diagnosis or treatment of ALCOHOL or DRUG ABUSE. If I authorize the release of this information, I understand that such information cannot be re-disclosed by a recipient without my specific consent.

_____ **MENTAL HEALTH RECORDS**.

I DO authorize the disclosure of any information relating to the diagnosis or treatment of MENTAL HEALTH. Indicate if you want to review the Mental Health records before released.

_____ I **DO** want to review the MENTAL HEALTH record before it is released
_____ I **DO NOT** want to review the MENTAL HEALTH record before it is released.

_____ **HIV RECORDS.**

I **DO** authorize disclosure of information which refers to HIV test results, infection status or treatment.

This disclosure is for the purpose of: _____

I understand that:

- I can refuse to disclose some or all of the information in my treatment records, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences. I understand I will not be denied treatment for refusing to disclose information.
- I can revoke all or part of this authorization at any time by written notice to Ilanka Community Center, except where information has already been acted upon for the release of my protected health information.
- I can cross out any provision on this form with which I disagree.
- If information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the person or entity that receives this information.
- This release may not include records generated at other facilities unless expressly requested above.
- I understand I am entitled to a copy of this authorization, upon request.

This authorization is effective for one year from the date of signing.

I authorize future disclosures to the same individual and/or entities during this time period.

_____ _____
Signature of Patient | Date

_____ _____
Signature of Legally Authorized Representative | Relationship and Date

_____ _____
Printed Name of Authorized Representative | Witness

Information Released
Pgs._____ Date: _____
Method:
□ In Person → □ ID verified
□ Mail □ Fax
Staff Initials_____