3137 Tongass Ave
Ketchikan, AK 99901

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Authorization for Release of Medical Information

(Last, First, M.I) **Patient Name**_____	***SSN*** _____-_____-_____ ***DOB***_____/_____/_____

Release from:	***Release to:***
_____ *(Facility Name)*	_____ *(Facility Name)*
_____ *(Phone)*	_____ *(Phone)*
_____ *(Fax)*	_____ *(Fax)*

Purpose of Release:

☐Continuing Medical Care	☐Work Comp	☐Disability Determination	☐ Personal
☐Insurance Claim	☐Application for Insurance	☐Other: _____	

Information to be Released:

Service Dates: From: _____ To: _____ **OR**

☐ all future records until this Authorization expires.

☐ ALL RECORDS *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe)*.

☐ Discharge Summary	☐ ER Records	☐ History & Physical	☐ Clinic Visit Notes
☐ Psychological Evaluation	☐ EKG/Cardiology Reports	☐ Immunization Records	☐ Other_____
☐Lab / Pathology Reports	☐ Radiology Images	☐ Radiology reports	☐Alcohol/Drug Treatment Records

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits

Signature *(required)*	**Date Signed** (required)
Relationship, If Not Patient:	