

Sitka Community Hospital
RELEASE OF INFORMATION REQUEST & AUTHORIZATION

Please contact Health Information Management staff at (907) 747-1743 for current processing charges.

1. **Authorization:** I authorize disclosure of medical information and health records as described below:

Name of Patient: _____ Date of Birth: _____

Telephone: _____

2. **Records Requested From:** The following organization is authorized to make the disclosure:

Sitka Community Hospital
209 Moller Avenue
Sitka, Alaska 99835

Phone: (907) 747-1743

Fax: (907) 747-1758

3. **Records to be Released To:** _____

4. **Type of Information:** This authorization does not apply to the following type(s) of information unless my initials appear beside each applicable category.

<input type="checkbox"/> Psychiatric Records	<input type="checkbox"/> Treatment for Alcohol and/or Drug Abuse	
<input type="checkbox"/> HIV Test Results (Human Immunodeficiency Virus)	<input type="checkbox"/> Operative/Procedure Reports	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> History/Physical Exam
<input type="checkbox"/> Laboratory Tests	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Billing Information	<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> Emergency Dept. Reports
<input type="checkbox"/> Other (please specify): _____		

5. **Dates of Service:** From ____/____/____ To ____/____/____

6. **Use of Information:**

Continuing Medical Care Second Opinion Personal Insurance Legal
 Other (please specify): _____

7. **Duration:** *This Authorization is valid for 3 months from the date next to my signature, unless otherwise noted here:* _____

8. **Signature:**

Printed Name: _____

Signature: _____ Date/Time: _____

If signed by other than patient, indicate relationship to patient: _____

Witness Signature: _____ Date/Time: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 3 months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or receive copies of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.