Interior Women's Health
1626 30th Ave.
Fairbanks, AK 99701

Phone: 907.479.7701
Fax: 907.479.7718

Authorization for Release of Medical Information

Patient Information

Patient Name:		Date of Birth	Last 4 SSN:	
Maiden/Other Name:		Primary Ph:	Secondary Ph:	
Address:	City		ST	Zip

Authorization

I hereby authorize Interior Women's Health to: □ *Release Records To*: □ *Obtain Records From*:

Person/Organization:	Phone:	Fax:	
Address:	City	ST	Zip

Purpose of Disclosure

□ Personal Use □ Legal □ Insurance □ Transfer of Care
□ Coordination Care □ Other (specify)_____

Dates of Service Requested

From:_____ To: _____
Specific Date: _____

Information Requested

□ Complete Record □ Chart Notes □ OB Record(s)
□ Vaccine Record □ Radiology □ Pathology
□ Billing Records □ Consultation □ Op Notes
□ Procedure □ Pap/Colpo/Leep □ Other:

Specify:_____

Request Format

□ Pick Up □ Mail □ Fax _____
□ Courier

Restricted Information

Check if you **DO NOT** authorize information related to:
□ Substance Abuse □ Mental Health
□ STD/HIV □ Genetic Information

Consent

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or other drug abuse and genetic testing; my signature authorizes the release of such information.

I may refuse to sign this authorization form. I understand IWH will not condition or deny treatment on my signing this authorization. I understand I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. IWH's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless revoked sooner, this authorization will 12 months from the date signed. I understand that if this information is disclosed to a third part, the information may no longer be protected by state or federal regulations and I release IWH, its employees and agents from any legal responsibility or liability for disclosure of the above information.

The above information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you form making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The general authorization for the release of medical information and other information is not sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Signature:	Date:
Signature of Legal Representative:	Relationship:

IWH Clinic Use Only

Chart/Acct#_____ Received By: _____

Date of Request: _____ Date Needed: _____

Receiving Provider: _____

Date Completed: _____Completed by:_____
□ Mail □ Fax □ Courier □ Pick Up

Patient ID/DL #_____

Additional Information

Fee: The first ten (10) pages of your medical records will be provided at no cost to you. After the tenth page, IWH will charge $.15 per page to cover the administrative cost of preparing your medical records. Payment will be due at the time of pick up.

Availability: IWH understands the importance of providing medical records in a prompt manner and it is our goal to do so as soon as possible. We politely ask that you give our office a minimum of 72 (business) hours to prepare your medical records. There are times when it may take our office longer than 3 business days to prepare your records and in this case we will do our best to notify you of this delay. In urgent situations our office will use its best judgment to provide the necessary records as soon as practical. If your request is due to an urgent need please inform our office immediately.