Family Medical Clinic

206 W. Rockwell Ave Ste. 100

Soldotna, Alaska 99669

907-262-7566

Fax: 907-262-0809

REQUEST TO RELEASE MEDICAL INFORMATION

Information is being requested for the following purposes (please check one):

____ Patient Treatment ____ Payment/Billing ____ Insurance/Legal

Patients Full Name: _____ DOB: _____

Former Name(s): _____

Phone Number: _____

I authorize Family Medical Clinic to **RELEASE** or **OBTAIN** the following protected health information from dates ____/____/____ through ____/____/____ from the following physician(s) and/or clinic(s)

_____ :

_____ Consult _____ Films/Images _____ Pathology

_____ Billing _____ Labs _____ EKG

_____ Pain Contract _____ Heartwise Results _____ ALL RECORDS

I acknowledge that the information requested may include material that is protected by federal law. My initials below authorize the release of this requested information.

_____ Drug/Alcohol Treatment _____ Mental Health _____ HIV

This authorization to release my protected health information is valid for 90 days from the date of signature and may be revoked in writing at any time.

_____ _____

Patient or Guardian Signature Date

*** Section 164.501(c)(1) of the HIPPA Privacy Regulation states a covered entity is not required to obtain a patient authorization to sue or disclose PHI for treatment, payment, or its own care operations. ***