Fairbanks Clinic, Inc.

1919 Lathrop St. Suite 100
Fairbanks, AK 99701
(907) 452-1761 Fax (907) 452-4642

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Notice: This request is not valid until all requested information is provided.

Patient Name: _____ Patient Date of Birth: _____

Address: _____ Phone Number: _____

I authorize the release of Personal Health Information: from □ to □

_____
Physician/Facility/Self

_____
Facility Address

And sent: from □ to □

Fairbanks Clinic, Inc.
1919 Lathrop St, Ste 100
Fairbanks AK 99701

We receive from FMH Courier

Reason for Request of Records:

□ Consult □ Referral □ Transfer of Care
□ Legal □ Other (Please specify): _____

Records to be released:

Dates: □ For the Date Range of: _____ to _____ *OR* □ All Past Dates

□ All Records from Specified Date Range Above *OR*

□ Chart Notes, consults, physicals, related procedures □ Immunizations
□ Labs / X-Ray Reports □ Other (Please specify): _____

Delivery of Records: □ Pick Up □ Mail □ Fax (specify #) _____

_ 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 services department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that this consent is valid for one year from date of signing.

_ I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_ I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_ I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or Human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____
Signature Date Relationship if other than patient

OFFICE USE ONLY

Records Sent: _____
Date Completed: _____ Completed by: _____

Picked Up Signature_____ **Date**_____ **Printed Name**_____

Updated 8/24/16