

**Creekside Family Health Clinic, Inc.  
Cherish Health Clinic**

**Authorization To Release  
Protected Health Information**

320 Bawden Street, Suite 313  
Ketchikan, AK 99901  
(907) 220.9982 (phone)  
(907) 220.9972 (fax)

Name of patient: \_\_\_\_\_  
Street address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone number: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
SS#: \_\_\_\_\_

**Release from:** \_\_\_\_\_

Ketchikan Medical Center     PHMG General Surgery     PHMG Orthopedics & Sports Medicine  
 PHMG Pediatrics     PHMG Primary Care Clinic     PHMG Women's Health Clinic

(Address) \_\_\_\_\_

**Release to: (Creekside Family Health Clinic, Inc. and Cherish Health Clinic)**

**Reason for release:**

**At the request of the patient or legal/personal representative.**  
 **Other Purposes (specify each purpose)** \_\_\_\_\_

**Specified information to be released:**

Dates of treatment: \_\_\_\_\_

Type of treatment:  Inpatient  Emergency room reports  
 Consultation Report  Emergency Room  History & Physical  
 Operative Report  Laboratory Reports  
 Discharge Summary  Pathology Report  X-ray Reports  
 Other (specify): \_\_\_\_\_  
 Mutual Exchange of Information between the entities listed above.

**Authorization:**

**I understand that** the information disclosed may contain testing or treatment information relating to Mental Health; Drug and/or Alcohol Abuse Treatment; Sexually Transmitted Diseases; HIV/AIDS virus.

**I understand that** once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulation.

**I understand that** this form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the Health Information Management Department. **I understand that** refusal to sign this authorization does not condition treatment.

**I understand that** this authorization will expire sixty (60) days from the date signed unless otherwise specified.

Date, event or condition on which authorization will expire if other than 60 days: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Signature of Other Authorized Person\* \_\_\_\_\_

Relationship to Patient or Authority to Act for Patient: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date Signed: \_\_\_\_\_

\*Authorization must be signed by the parent or legal guardian of any patient under 18; the legal guardian of any patient under guardianship; the personal representative of a deceased patient, or if no personal representative, the spouse, any adult child of a deceased patient (Chapter 8 of 1.C 16-4, Acts of 1982). If patient is under 18, records are protected by Federal Law (42 CFR, part 2) regarding drug and alcohol abuse, authorization must be signed by both patient and parent or legal guardian.