Authorization to Release

Protected Health Information

Creekside
FAMILY HEALTH CLINIC

320 Bawden Street, Suite 313
Ketchikan, Alaska 99901
Phone: (907) 220-9982 Fax: (907) 220-9972

Name (*First, Middle, Last)*	Birth Date (*Month, DD, YYY)*

Release Information From:

☐ Creekside Clinic, 320 Bawden St. #313
Ketchikan, AK 99901
☐ Other *(Specify facility/individual & address below, including phone/fax if known).*

_____
_____
_____
_____

Release Information To / Provide Authorization For:

☐ Creekside Clinic, 320 Bawden St. #313
Ketchikan, AK 99901
☐ Authorized Individual or Facility *(Specify facility/individual & Address below, including phone/fax if known).*

Purpose of Release/Authorization:

☐ Treatment/Continued Care
☐ Application for Insurance
☐ Personal
☐ Legal Purposes
☐ Payment of Insurance Claim
☐ Disability Determination
☐ Coordinate Appointments
☐ Pick Up Prescriptions
☐ Discuss My Medical Plan
☐ Mutual Exchange of Information

Information to be Released:

Service Dates
*From:*_____ *To:*_____ Information Needed by:_____

☐ History and Physical
☐ Immunization Records
☐ Outpatient Clinic Notes
☐ All Records x two years
☐ EKG's
☐ Pathology Reports
☐ Operative Reports
☐ ER Reports
☐ Laboratory Reports
☐ Radiology Reports
☐ Radiology Images
☐ Other
☐ Hospital Notes
☐ Hospital Discharge Summary
☐ Billing Information

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law.

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here:_____

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years or age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient if 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.
  ☐ Parent ☐ Legal Guardian

Signature (*Required)*	**Date Signed** (*Required*) (*Month, DD, YYY)*

Printed Name of Person Signing (*If Not Patient)*

Mailing Address of Patient (Street or P.O. Box)

City	State	Zip Code	Phone