



## Authorization to Release Protected Health Information

1225 Tongass Avenue  
Ketchikan, Alaska 99901  
Phone: (907) 220-9982 Fax: (907) 220-9972

|                            |                         |
|----------------------------|-------------------------|
| Name (First, Middle, Last) | Birth Date (MM/DD/YYYY) |
|----------------------------|-------------------------|

**Release Information From:**

Creekside Clinic, 1225 Tongass Ave  
Ketchikan, AK 99901

Other (Specify facility/individual & address below, including phone/fax if known).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Release Information To / Provide Authorization For:**

Creekside Clinic, 1225 Tongass Ave  
Ketchikan, AK 99901

Authorized Individual or Facility (Specify facility/individual & Address below, including phone/fax if known).

**Purpose of Release/Authorization:**

|  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Treatment/Continued Care  | <input type="checkbox"/> Legal Purposes             | <input type="checkbox"/> Coordinate Appointments | <input type="checkbox"/> Discuss My Medical Plan        |
| <input type="checkbox"/> Application for Insurance | <input type="checkbox"/> Payment of Insurance Claim | <input type="checkbox"/> Pick Up Prescriptions   | <input type="checkbox"/> Mutual Exchange of Information |
| <input type="checkbox"/> Personal                  | <input type="checkbox"/> Disability Determination   |  |   |

\_\_\_\_\_

**Information to be Released:**

Service Dates  
From: \_\_\_\_\_ To: \_\_\_\_\_ Information Needed by: \_\_\_\_\_

|  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> History and Physical    | <input type="checkbox"/> EKG's             | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Hospital Notes             |
| <input type="checkbox"/> Immunization Records    | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Radiology Reports  | <input type="checkbox"/> Hospital Discharge Summary |
| <input type="checkbox"/> Outpatient Clinic Notes | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Radiology Images   | <input type="checkbox"/> Billing Information        |
| <input type="checkbox"/> All Records x two years | <input type="checkbox"/> ER Reports        | <input type="checkbox"/> Other              |   |

\_\_\_\_\_

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 is 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) (MM/DD/YYYY) |       |
| Printed Name of Person Signing (If Not Patient) |       |                                     |       |
| Mailing Address of Patient (Street or P.O. Box) |       |                                     |       |
| City  | State | Zip Code                            | Phone |