1919 Lathrop St. Suite 222

Fairbanks, AK 99701

Phone: (907) 456-8191 Fax: (907) 456-8192

REQUEST FOR MEDICAL RECORDS

I hereby authorize Chena Health to:

_____ Release Information To: _____ Obtain Information From:

Person/Agency: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Information Requested:

DATE RANGE: _____ Last Three Years **or** _____ *to* _____

	Visit Notes		Pregnancy Information Only
	Immunizations		Outside Records (Releasing from Chena Health Only)
	Labs		Patient Communications
	Imaging		Other:

Purpose of Information:

Information listed above will be disclosed for the following purposes:

_____

I understand that my medical record may include sensitive information including but not limited to the Diagnosis & treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), HIV status and/or STD's. I understand & agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

PLEASE INITIAL THE STATEMENT THAT APPLIES: (you must initial one)

I do _____ do not _____ authorize this information to be released

Expiration, Revocation, and Redisclosure of Authorization:

This authorization will expire 1 year from the date of signature. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this signed authorization by notifying Chena Health in writing. When your medical information is released pursuant to a valid authorization you should be aware of the following: That the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient/Legal Representative Date

_____

Relationship to Patient