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Fairbanks, AK 99701

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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	Patient Communications
Labs	Consent for Open Communication
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