SEWARD COMMUNITY HEALTH CENTER
AUTHORIZATION TO RELEASE HEALTH INFORMATION
FAX RECORDS TO: 907-224-8501

Patient Name: _____ **DOB:** _____

SEND MY HEALTH INFORMATION TO SCHC

☐ I would like the provider indicated below to send my medical records to Seward Community Health Center via
☐ Mail ☐ Pick Up ☐ Fax

Medical Group/Provider Name: _____

Address: _____

City: _____ **State:** _____ **Postal Code:** _____

Phone: _____ **Fax:** _____

HAVE SCHC RELEASE MY HEALTH INFORMATION TO THE PROVIDER/PRACTICE OR AUTHORIZED INDIVIDUAL BELOW

☐ I would like SCHC to send my medical records/release my health information to the provider/practice/individual below via
☐ Mail ☐ Pick Up ☐ Fax

Provider/Practice/Individual's Name: _____

Address: _____

City: _____ **State:** _____ **Postal Code:** _____

Phone: _____ **Fax:** _____

WHAT IS THE PURPOSE OF HEALTH INFORMATION RELEASE? Check all that apply.

☐ Personal ☐ New Physician ☐ Social Security Disability ☐ Primary Care Physician
☐ Medical Ins. Claim ☐ Life Insurance ☐ Consultation ☐ Worker's Compensation
☐ Attorney/Legal ☐ Other: _____

DESCRIBE THE HEALTH INFORMATION TO BE RELEASED

Date information needed by: _____

Service Dates from: _____ **to:** _____

☐ Complete Medical Record ☐ History & Physical ☐ Laboratory Results ☐ Clinic Notes
☐ Immunization Records ☐ Pathology Reports ☐ Radiology Reports ☐ EKGs
☐ Other: _____

- I hereby authorize Seward Community Health Center to release/obtain all medical information with respect to the treatment of the above referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and / or confidential HIV related information.
- I understand that Seward Community Health Center will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization. I understand that I may revoke this Authorization at any time by providing written notice to Seward Community Health Center. I understand that I may not be able to revoke this Authorization if Seward Community Health Center has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.
- I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.
- I also understand that if the Protected Health Information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Alaska State Law.

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

_____ _____
Signature of Patient or Person granting Authorization on behalf of patient Date

_____ _____
Printed Name of Person Signing (If Not the Patient) Relationship to Patient