Petersburg Medical Center
PO Box 589, 103 Fram Street
Petersburg, Alaska 99833
Telephone: (907) 772-4291 Fax: (907) 772-4387

AUTHORIZATION TO DISCLOSE OR OBTAIN HEALTH INFORMATION

Hospital Medical Records Fax (907) 772-4387 - Clinic Medical Records Fax (907) 772-9273

Patient Name: _____ **Date of Birth:** _____ **MR Number:** _____
Address: _____ _____ **Phone:** _____

☑ **I authorize Petersburg Medical Center to DISCLOSE my health information TO:**
Name _____
Address _____
City _____ State _____ Zip _____
Phone # _____ Fax # _____

☐ **I authorize Petersburg Medical Center to OBTAIN my health information FROM:**
Name _____
Address _____
City _____ State _____ Zip _____
Phone # _____ Fax # _____

Specific medical information that may be disclosed/obtained:

☐ ER Report	☐ Laboratory Reports	☐ *Drug/Alcohol Treatment
☐ History & Physical	☐ X-Ray Reports	☐ *AIDS/HIV Test Results
☐ Discharge Summary	☐ Clinic Notes	☐ *Psychiatric Information
☐ Operative Report	☐ Other: _____	

Dates: From _____ To _____

***Purpose of disclosure is required for starred (*) items.**

The information will be used/disclosed for the following purposes:
☐ Continued Care ☐ Personal ☐ Legal ☐ Other: _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I acknowledge that I have read the disclosures on the back (or page 2) of this Authorization form, and understand that I have the right to revoke this Authorization (except to the extent that Petersburg Medical Center has already used or disclosed the information in reliance on this Authorization) by signing the Revocation of Authorization to Release Information form. This authorization expires _____ (insert applicable date or event). If I fail to specify an expiration date or event, this authorization will expire 90 days from the date signed.

_____ _____
Signature of Patient or Legal Representative Date Signed

_____ _____
If signed by Legal Representive, relationship to patient Signature of Employee Releasing Record

If Petersburg Medical Center is requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:
- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You may review Petersburg Medical Center's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Authorization.

Because we have the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice is posted in our office indicating the effective date of the Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do argee, we are required
to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

Additional Federal Substance Abuse Confidentiality Requirements

***Item #4* - Under the Federal Substance Abuse Confidentiality Requirements, an authorization must include the purpose of the disclosure of substance abuse information even if the patient requests the disclosure.**

[If PMC seeks an authorization from just an individual for a use or disclosure of protected health onformation, the covered entity must provide the individual a copy of the signed authorization.]