SVT Health&Wellness *Partnering in the Journey!*
A branch of Seldovia Village Tribe

Panel Clinician:_____
Review Patient's choices & initial:
Initial:_____ Date_____

RELEASE OF INFORMATION AUTHORIZATION FORM

Patients: Please complete sections 1-5, sign and date. See Reverse for Instructions

1. Patient Name: _____ Date of Birth: _____

Release ☐ From ☐ To

SVT Health & Wellness
Attn: Medical Records
880 E End Rd
Homer, AK 99603-7201
Phone: 907-226-2228 Fax: 907-435-3223

Release: ☐ From ☐ To (please list)
Name: _____
Organization: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____

2. Information Being Requested *(please check all that apply)*:

☐ Current Physical ☐ Medication List ☐ Labs/test results
☐ X-ray/Diagnostic reports ☐ ER/Hospital Visit ***DATE***_____ ☐ Birth Record
☐ Behavioral Health records ☐ **Colon/Cervical Cancer Screening Results** ☐ Other: _____
☐ ***Reproductive Health History** (*if patient is under 18, patient **must** sign this release, **not** parent/guardian)

3. Date Range: ☐ Most Recent ☐ Previous 12 months ☐ Date Range: _____

****We are unable to process requests to import "complete medical record" from an outside clinic **unless your Clinician approves******

4. Purpose of the Request *(REQUIRED: please check one)*:

☐ ***Patient Request ☐ Coordination of Care ☐ Transfer of Care
☐ Insurance Request ☐ Termination of Care ☐ Other: _____

5. Patient *Initial*:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I consider a copy of this authorization to be as valid as the original. I understand that if the organization authorized to receive the information is not a health plan or

____Yes ____ No health care provider the released information may no longer be protected by federal privacy regulations. I understand that I may see and obtain a copy of the information described on this form if I ask for it and that I may get a copy of this form after I sign it. I understand that a fee for copies may be imposed by the person(s)/organization(s) listed above or by its designated business associate. I understand that the first complete records request will be provided free of charge once every 12 months. All subsequent requests within a 12-month period will incur additional fees.

____Yes ____ No I understand that I may revoke this authorization at any time by notifying SVTHW in writing, and it will be effective on the date the notification is received, except to the extent action has already been taken prior to receiving it.

____Yes ____ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Definition: *Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq. includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.*

____Yes ____ No I authorize the release of any records regarding drug, alcohol, and psychiatric or mental health treatment to the person(s) listed above.

Signature: _____ Date Signed: _____
Print Name: _____ ☐ Patient ☐ Parent ☐ Legal Guardian

THIS AUTHORIZATION EXPIRES 1 (ONE) YEAR AFTER "Date Signed" ABOVE.

For assistance with this form: **907-435-3211**. For HIPAA / Privacy Questions: **907-435-3210**

"How do I complete the Release of Information Form?"

The ROI form is used to **send** or **receive** personal health information. There are 5 sections on the form.

Section One is your name and address, and the name and address of the location you'd like records sent to, or received from.

Section Two lets you, or your Clinician, choose information to be sent. Please choose recent records that are **relevant** to the care you need NOW. Ask your Clinician what is **relevant** before requesting multiple records.

Section Three lists a Date Range for the records in question. Make your selection.

Section Four: Purpose of your Request.

Patient Request: Your Clinician will review before sending.

Coordination of Care: Records from a recent visit, surgery, hospitalization

Transfer / Termination of Care: Moving, changing provider or care location? ***Check one***.

Insurance Request: Let us know if the records request has to do with your insurance.

Section Five: Initial next to **Yes** or **No** on each line**. NO** Check Marks Please**!**

Sign, print, date. **You're done!**

Please ask a team member to assist you, if needed.
We are happy to help.

STAFF USE ONLY: ROI forms, signed and reviewed, may be scanned to documents and placed in the "ROI" inbox for processing.

Urgent requests may be hand delivered to the Release of Information/Medical Records office, but are still subject to ordinary timelines