



**SVT**  
**Health & Wellness**  
A branch of Seldovia Village Tribe

*Partnering in  
the Journey!*

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:

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

### Date of Birth:

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

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Current Physical   | <input type="checkbox"/> Medication List                                | <input type="checkbox"/> Labs/test results |
| <input type="checkbox"/> X-ray/Diagnostic reports   | <input type="checkbox"/> ER/Hospital Visit <u>DATE</u> _____            | <input type="checkbox"/> Birth Record      |
| <input type="checkbox"/> Behavioral Health records  | <input type="checkbox"/> <b>Colon/Cervical Cancer Screening Results</b> | <input type="checkbox"/> Other: _____      |
| <input type="checkbox"/> <b>*Reproductive Health History</b> (*if patient is under 18, patient <b>must</b> sign this release, <b>not</b> 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):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> ***Patient Request | <input type="checkbox"/> Coordination of Care | <input type="checkbox"/> Transfer of Care |
| <input type="checkbox"/> Insurance Request  | <input type="checkbox"/> Termination of Care  | <input type="checkbox"/> Other: _____     |

### 5. Patient Initial:

\_\_\_\_\_ Yes \_\_\_\_\_ No 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 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 venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

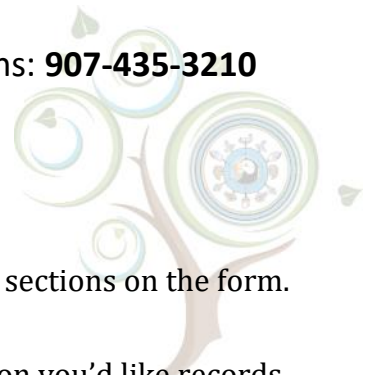
\_\_\_\_\_ Yes \_\_\_\_\_ No I authorize the release of any records regarding drug, alcohol, and psychiatric or mental health treatment to the person(s) listed above.

Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_

Date Signed: \_\_\_\_\_  
☐ 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.*