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

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

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)
Full Name: _____
Organization: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____

2. Information Requested/Released *(check all that apply)*:

☐ Current Physical
☐ X-ray/Diagnostic reports
☐ Labs/test results
☐ Medication List
☐ Progress Notes
☐ Reproductive Health History (if patient is under 18, patient **must** sign this release, **not** parent/guardian)
☐ Colon/Cervical Cancer Screening Results
☐ Behavioral Health records
☐ Pertinent Information
☐ Other: _____
☐ Open/Verbal Communication

Hospital Records:
☐ Discharge Summary
☐ History & Physical
☐ Operative/Procedure Reports
☐ Diagnostic Test Results
☐ Emergency Room Visit Summary

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

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

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

5. Patient Initial:

____**Yes**
____ **No**

I hereby authorize the use or disclosure of my protected health information as described above. I understand that this authorization is voluntary and I do not have to sign. My refusal to sign this authorization will not affect my ability to receive health care treatment, payment, enrollment or eligibility for benefits, except in the circumstance that the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. 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, health care clearinghouse, or health care provider, the released information may no longer be protected by federal privacy regulations (45 CFR Part 164, Subpart E). 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 may request a copy of my health record at SVTHW once every 12 months free of charge. All subsequent requests within a 12-month period may incur fees. **I understand that I may sign up for the SVTHW patient portal at any time to view, download and/or transmit my healthcare records free of charge.**

____**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 containing drug, alcohol, psychiatric or mental health treatment to the person(s)/organization listed above.

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

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

For assistance with completing this form, contact Medical Records: **907-226-2228 ext. 126**.
For HIPAA / Privacy Questions: **907-435-3217**

"How do I complete this form?"

This form is used to **send** or **receive** patient's protected health information. There are 5 sections on the form:

1. **Section One** is the patient's name and address, and the name and address of the location to send the records to/request records from.
2. **Section Two** lets the patient, or Clinician, choose what information is to be sent or requested. Choose recent records that are **relevant** to the care needed NOW. Ask Clinician what is **relevant** before requesting multiple records.
3. **Section Three** lists a Date Range for the records in question. Make a selection.
4. **Section Four:** Purpose of Request.
    a. **Patient Request:** Clinician will review before sending.
    b. **Coordination of Care:** Records from a recent visit, surgery, hospitalization
    c. **Transfer / Termination of Care:** Moving, changing provider or care location? ***Check one***.
    d. **Insurance Request:** Let us know if the records request has to do with insurance.
5. **Section Five:** Initial next to **Yes** or **No** on each line**.** **NO** Check Marks**!**

Sign, print name, date.

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