SVT HEALTH & WELLNESS
880 East End Rd, Homer, AK 99603
Email:medicalrecords@svt.org Phone: 907-435-3240 Fax: 907-435-3223

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT

Name:_____ **Birth Date:** _____ /_____ /_____

Other Names Used:_____

FROM

I request patient's information be sent by:

☐ SVT Health & Wellness

☐ Another health care provider name here**:**_____

PROVIDE TO

Who do you want the patient information to be sent to?

Name:_____ **Phone Number:**_____

How do you want the medical information to be sent?

☐ It will be picked up.

☐ Mail to this address**:**_____

☐ Fax to**:** _____*****

☐ Email to**:**_____*****

☐ Other (describe)**:**_____

*****Sending information by Fax or Email increases privacy risks, as they involve increased risk of accidental disclosure. Information sent electronically may also be vulnerable to cyber attack.

Record Format: ☐ Paper ☐ Other: _____ *Note:* If no selection is marked, paper records are mailed.

REQUESTED INFORMATION

Health information Requested/Released:

☐ Consultations
☐ Medications Records
☐ Laboratory Results
☐ Immunization Record
☐ Complete Record
☐ Discharge Summaries
☐ Physician Reports
☐ Pathology Reports
☐ EKG Reports
☐ Sleep Study
☐ History & Physical Exams
☐ Nursing Notes
☐ Radiology & Imaging Reports
☐ Emergency Dept. Records
☐ Reproductive Health History(if patient under 18, patient **must** sign this release)

☐ **Records for the following dates or treatment** :_____

☐ Other**:**_____

Specific Sensitive Information needs to be initialed to be disclosed:

___Mental/Behavioral Health Treatment ___Drug/Alcohol Abuse ___HIV/AIDS Information ___STD Treatment

PURPOSE

Why are you requesting this disclosure?

☐ Personal Use ☐ Legal ☐ State/Federal ☐ Insurance/Benefits ☐ Care Coordination ☐ School ☐ Other**:**_____

VALIDITY

Expiration: This authorization will expire one (1) year from the signature date, unless an alternative expiration date is provided here: ___/___/___ **Revocation:** An authorization may be revoked at any time by written notice to SVT Health & Wellness Health Information Management. Revocation is not effective until notice is received and is not effective regarding disclosures made before revocation and where authorization was obtained as a condition of insurance coverage.

PATIENT RIGHTS

I understand that: (1) I have a right to receive a copy of this signed authorization upon request; (2) I have a right to refuse to sign this authorization - SVT Health & Wellness may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form; and (3) I have a right to inspect or receive a copy of my health information. I may arrange to do so by contacting Health Information Management. I may be charged a reasonable fee for copying costs.

REQUESTOR

I authorize the disclosure of health information described above. Information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy standards, including HIPAA and the Privacy Act of 1974. A photo copy/fax of this form is as valid as the original.

Signature:_____**Date:** ____ /____/____

Print Name:_____

Relationship to Patient: ☐ Self ☐ Parent/Guardian ☐ Legally Authorized Representative ☐ Other: _____

Mailing Address:_____**City:**_____ **State:**_____**ZIP:**_____

How should we contact you if there are questions? ☐ Phone:_____ ☐ Email:_____

OFFICE USE ONLY: MRN #:_____ Verification Method:_____ □ Priority or □ Archive

Sent by: □ PU □ Mail □ Fax □ Email □ Other:_____ Date Sent: _____/_____/_____ Staff Initials:_____