SVT HEALTH & WELLNESS
880 East End Rd, Homer, AK 99603
Email:medicalrecords@svt.org Phone: 907-226-2228 Fax: 907-531-7361

PCP Requesting: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name:	**Date of Birth:**	**Medical Record #:**
Other Names Used:	**Address:**	
City, State & Zip Code:	**Phone/Contact Number:**	

I authorize SVT Health and Wellness to: (check all that apply) ☐ -**RELEASE** Information To: ☐ -**OBTAIN** Information From:

Organization Name:	**Specify Department, Job Tile, or Name of Person to receive information:**
Mailing Address:	**City/State/Zip:**
Phone/Contact Number:	**Fax Number:**

RECORD FORMAT

How do you want the medical information to be sent?
☐ It will be picked up. ☐ Mailed ☐ Faxed* ☐ Emailed* ☐ 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

Record Date Range: _____

Health information Requested/Released:

☐ Consultations
☐ Medications Records
☐ Laboratory Results
☐ Immunization Record
☐ Complete Newborn 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)
☐ 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: _____

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:_____