PCHS

Patient Authorization for Release of Information

To have your records released **or** to obtain your medical records, you must provide the following information to us ***for each entity or organization you want records sent to or obtained from.*** Please note PCHS is the custodian of records for Peninsula Medical Center/Dr. Marcus Deede and Legends Dental. If you would like Peninsula Medical Center/ Dr. Marcus Deede or Legends Dental records released, you will need to complete a separate form.

Please check the box for which records you would like released or requested.

PCHS Main Office
230 E Marydale Ave
Soldotna, AK 99669
Phone (907) 262-3119
Fax (907) 262-9290

This disclosure is for: ☐ **Personal** ☐ **Legal Request** ☐ **Further Medical Care**

First Name:	Last Name:	
Prior Name(s):	Date of Birth:	
Phone Number:		
(Choose ONE only) I hereby authorize PCHS to: ☐ ***GET*** my records **FROM:** **~OR~** ☐ ***SEND*** my records **TO:**		
Name:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Email (all emails are sent encrypted):		

Records to be released or obtained:

	Primary Care Medical Records		Lab/X-ray Results
	Eye Care Clinic Records		Dental Records
★	Behavioral Health Counseling/Integrated Assessment		Physical/Occupational Therapy Records
★	Psychiatric Records		Referral Consult Notes
	Other (explain):		
	Complete Designated Record Set (must initial appropriate sections for protected records to be included)		

I understand that this request may include diagnoses, consultations, evaluations, Assessments, Treatment Plans, tests/results, medications, and treatment for Medical, Behavioral, Psychiatric, Substance/Alcohol Use, Vision, Physical/Occupational Therapy, and/or Dental records.

I understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health, genetic testing, reproductive health, and drug & alcohol diagnosis/treatment/referral information.

Date Range of Records Requested:

☐ Last 2 Visits ☐ Last 2 Years ☐ Date Range (please write the dates): _____

Please Sign Back of Form – Release is Not Valid Without Signature

*I understand and agree that the information below will be **disclosed ONLY if I place my initials in the applicable space**:*			
★	HIV/AIDS testing information/results	★	**Mental Health** specific visits (will be sent if Behavioral Health or Psychiatry are initialed on first page)
★	**Substance/Alcohol Use** treatment visits/progress notes/non-compliance.	★	Genetic testing

Terms of Consent - I understand the terms of my consent. I understand that:

a. PCHS is an integrated facility and uses an integrated medical record which means that records sent may contain medical, psychiatric, dental, behavioral health, or substance and alcohol use information.
b. When using a general designation in the "Person/Organization" section, I have the right to obtain, upon request, a list of entities to whom my information has been disclosed, pursuant to a general designation.
c. I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.
d. There may be a fee associated with this request.
e. Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law.
f. I have the right to receive a copy of this signed authorization.
g. I may revoke this authorization in writing at any time. If I revoke this authorization, the information described above may no longer be disclosed for the purposes described above, with the exception of when PCHS has already taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

NOTICE TO RECIPIENT: This information has been disclosed to you and may contain records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This authorization is valid until the following date or event:
_____**. (one year from signature, if not stated.)**

Patient Signature	Print Name	Date
Parent or Legal Guardian/Rep Signature	Print Name/Relationship to Patient	Date

PCHS Main Fax: (907)262-9290
PCHS Alternate Fax: 1-877-835-3921