Turnagain Community Health

(formerly Girdwood Health Clinic)

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PO BOX 1130, GIRDWOOD, ALASKA 99587, Phone: 907-783-1355 Fax: 907-783-1357 or 855-289-0122

Patient Name: ____DOB:____________________Phone:__________________________
(Name of patient whose information is being released)

Mailing Address: ______________________________________City:____________________State:_______Zip:_________________

I, (☐ Patient ☐ Parent ☐ Legal Guardian) hereby authorize **Turnagain Community Health (TCH)** TO:

☐ Release information to **OR** ☐ Obtain information from (PLEASE ONLY CHOOSE ONE PER FORM)

(Provider/Clinic) Name: ____Phone: ______________________

Mailing Address:

Sensitive Information Notice: The medical records being released **may include** sensitive information related to:

- Mental Health/Behavioral Health
- Substance Use Disorder (SUD) Treatment
- HIV/AIDS-related information

Opt-Out of Sensitive Information: I understand that I have the right to exclude the release of sensitive information.

I DO NOT wish to release the following (check all that apply):

☐ TCH Behavioral Health Visit Records
☐ TCH Substance Use Disorder (SUD) Treatment
☐ HIV/AIDS-related Information
☐ Other: ______________________________

____FAX: __________________________

Information to be Released: (Must Check One)

☐ Encounters and Procedures (includes medication list and immunization record)
☐ Lab Reports ☐ Imaging Reports
☐ Medication List ☐ Vaccination History
☐ Other: ____

Date Range of Records to be released: (Must Check One)

☐ Records from the past 12 months
☐ Last 3 office visits
☐ Other:____

PURPOSE OF DISCLOSURE:

☐ Changing Provider ☐ Personal Use ☐ Consultation/Second Opinion ☐ Continuing Care ☐ Insurance

☐ School ☐ Legal ☐ Workers Compensation ☐ Other (please specify) ____

- I understand that authorizing the disclosure of this health information is voluntary.
- I understand that this authorization will expire 90 days after I have signed this form.
- I understand that I may revoke this authorization at any time by notifying Turnagain Community Health in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- By authorizing this release of information, my treatment, health care, eligibility for benefits, and payment for my health care will not be affected if I do not sign this form. I understand that I will get a copy of this form after I sign it. There is no charge for medical records if copies are sent to facilities for ongoing care or follow-up treatment.

____ ______________ OR ____ __________

PATIENT SIGNATURE DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

____ ______________ ____ __________

WITNESS (if required) DATE RELATIONSHIP TO PATIENT DATE