



P O Box 240 Kenai AK 99611 / Phone 907-283-9118 / Fax 907-283-5341

## Medical Records Request

The purpose of the disclosure is: Personal \_\_\_\_\_ Legal Request \_\_\_\_\_ Further Medical Care \_\_\_\_\_ Other \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize MediCenter to (please initial): \_\_\_\_\_ Obtain records from: \_\_\_\_\_ Release records to:

Person/Organization \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Please **initial** the information to be release or obtained:

\_\_\_\_\_ Demographic Information Only \_\_\_\_\_ Medical Records \_\_\_\_\_ Lab/X-ray results

\_\_\_\_\_ Psychological Test/Reports \_\_\_\_\_ Behavioral /Mental Health/Integrated Assessment \_\_\_\_\_ Other

All of my **MediCenter Health Records** from \_\_\_\_\_ to \_\_\_\_\_; I understand that this may include diagnoses, consultations, evaluations, Integrated Assessments, Treatment plans, test/results, medications, and treatment for all medical, Behavioral health, psychological, psychiatric, substance, and alcohol use. I understand and agree that the information below will be disclosed if I place my initials in the applicable space next to the type of information: \_\_\_\_\_ HIV/AIDS testing information/results; \_\_\_\_\_ Mental Health Specific visits \_\_\_\_\_ Genetic testing \_\_\_\_\_ Substance/Alcohol Use treatment visits/progress notes/non-compliance.

**This authorization is valid until the following date or event.** \_\_\_\_\_. **If no date or event is specified, the authorization will expire one year from the date you signed this release.**

I understand that: MediCenter is an integrated facility and uses an integrated medical record which means that records sent on your behalf may contain medical, psychiatric, behavioral health, substance, and alcohol use information. I have the right to refuse the 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 my affect my ability to receive health care services is if the health care services are research-related or solely for the purpose or providing health information to someone else and the authorization is needed to make that disclosure. \_\_\_\_\_ There may be a fee associated with this request. \_\_\_\_\_ Information used or disclosed pursuant to this authorization may be subject to a re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information. \_\_\_\_\_ I have the right to receive a copy of this signed authorization. \_\_\_\_\_ I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when MediCenter has taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

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.