Camai Community Health Center, Inc.
2 School Road / P.O. Box 211
Naknek, Alaska 99633
Phone: (907) 246-6155 – Fax: (907) 246-6158

AUTHORIZATION FOR USE OR DISCLOSURE HEALTH INFORMATION

I, _____
(Patient or Parent/Guardian Name)

Hereby authorize the disclosure of the following individuals protected health information:

Patient Information:

Name:_____ Date of Birth:_____

For the purpose of: ____ Continuation of Care ____ Other (Please Specify) _____

The following information may be disclosed (Please Check All That Apply):

☐ Entire Medical Record
☐ Medical Record from _____ to _____
☐ Lab or Pathology Reports
☐ Diagnostic Imaging Reports
☐ Clinical Office Chart Notes
☐ Billing Records
☐ Insurance Records
☐ Referrals

In compliance with Federal and State laws, the following items must be initialed to be included in the use or disclosure of other health information:

____ HIV/AIDS-related Information ____ Mental Health Information ____ Sexually Transmitted Diseases

____ Genetic Testing Information ____ Drug/Alcohol Treatment/Referral

Release of Information From:

☐ **Camai Community** Health Center
P.O. Box 211
Naknek, AK 99633
P: (907) 246-6155
F: (907) 246-6158

☐ **Name of Provider/Facility:_____**

Address:_____

_____

Fax:_____ Phone:_____

Release of Information To:

☐ **Camai Community** Health Center
P.O. Box 211
Naknek, AK 99633
P: (907) 246-6155
F: (907) 246-6158

☐ **Name of Provider/Facility:_____**

Address:_____

_____

Fax:_____ Phone:_____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until 1 year from the date of signing or upon the following specified date:

Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by giving written notice to the Camai Community Health Center, Inc. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** I understand this authorization may include disclosure of information relating to **DRUG/ALCOHOL TREATMENT/REFERRAL,** except for Alcohol and Drug Abuse as denied in 42 CFR Part 2**, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, **SEXUALLY TRANSMITTED DISEASES** and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Signature of Patient/Legal Representative

Printed Name of Patient/Legal Representative

If Legal Representative, relationship to Patient:_____ Date:_____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____

FOR OFFICE USE ONLY

Form of Photo ID Checked:

☐ **Driver's License#:_____** ☐ **Military ID** ☐ **Other:_____**

Witness:_____ Date:_____