Juneau Family Health and Birth Center

Release of Information

1601 Salmon Creek Ln, Juneau, AK 99801 phone: 907.586.1203 fax: 907.586.5765

Patient name: ___________________________________ Date of birth: ___________________________

SSN: ____ Phone: ________________________________

Information to be released to / from: ____

____

Purpose or need for this information:____

Type of information to be released: (Specify dates where required)
*Please note - charges may apply for multiple records requests.

___ Complete Patient File __________________________________ Dates:_____-ALL-__________________

___ Medical records ______________________________________ Dates:_________________________

___ Lab Results ____ Dates:_________________________

___Ultrasound/Radiology___________________________________ Dates:_________________________

___ Other Records____ Dates:_________________________

I understand that my record may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I release you from any legal responsibility or liability that may result from this authorization.

Patient authorization to release medical information:
I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

___________________________________ ______________________________ ________________

Signature of patient or responsible party Relationship to patient Date

___________________________________ ______________

Witness Date