222 Front St.
Fairbanks, AK 99701
Phone: (907) 451-7100
Fax: 1(866) 440-4399

AUTHORIZATION FOR THE RELEASE OF RECORDS

PATIENT NAME ______________________________ DOB ________________

RELEASE TO: HOLISTIC MEDICAL CLINIC
222 Front Street
Fairbanks, AK 99701

I AUTHORIZE ____________________
____
____
____

TREATMENT DATE
From/To: ____________________________

INFORMATION REQUESTED:

- [ ] CHART NOTES
- [ ] LAB REPORTS
- [ ] XRAY, X-RAY REPORTS
- [ ] SURGICAL REPORTS
- [ ] HOSPITAL REPORTS
- [ ] OTHER (specify)

____
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REASON FOR USE:

- [ ] MEDICAL TREATMENT
- [ ] LEGAL REQUEST
- [ ] WORKERS COMP.
- [ ] PATIENT BILLING
- [ ] OTHER (specify)

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I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health are/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that Holistic Medical Clinic will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Holistic Medical Clinic's Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, **it will expire 6 months from the date signed** or as specified: ____________

This consent for release of protected health information expires in 90 days. I understand I may review my medical records upon request and may revoke this request at any time. However, I am aware there maybe medical records that have already been released after the original authorization and prior to this revocation.
The Holistic Medical Clinic, its employees, and the attending doctor are hereby released from legal responsibility or liability of the above information.

____________________________________ ______________________________

Signature & Date Witness