



**Petersburg Medical Center**

PO Box 589

Petersburg, AK 99833

Hospital: Phone (907) 772-4291

Medical Records Fax: (907) 772-3085

Clinic Medical Records Fax: (907) 772-9273

Clinic: Phone (907) 772-4299

**AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Patient Name \_\_\_\_\_ MR# \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN# \_\_\_\_\_ Phone ( ) \_\_\_\_\_

I authorize the use/disclosure of health information about me as described below:

1. I authorize Petersburg Medical Center to obtain my health information from:

Name \_\_\_\_\_

Address \_\_\_\_\_

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

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

2. I authorize Petersburg Medical Center to release my Health Information to:

Name \_\_\_\_\_

Address \_\_\_\_\_

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

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

3. Description of specific medical information that may be used/disclosed (check):

\_\_\_\_\_ Discharge Summary      \_\_\_\_\_ Operative Report      \_\_\_\_\_ Pathology Report

\_\_\_\_\_ Laboratory Reports      \_\_\_\_\_ History & Physical Exam      \_\_\_\_\_ Xray Reports

\_\_\_\_\_ AIDS/HIV Test Results      \_\_\_\_\_ Drug/Alcohol Treatment\*      \_\_\_\_\_ ER Report

\_\_\_\_\_ Psychiatric Information      \_\_\_\_\_ Other: \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

\*Purpose of Disclosure is required if pertaining to substance abuse (see #4 below)

4. The information will be used/disclosed for the following purposes: **(Note: this item is not required if the disclosures are requested by the patient.)**

\_\_\_\_\_ Continued Care      \_\_\_\_\_ Personal      \_\_\_\_\_ Legal      \_\_\_\_\_ Other

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

**I acknowledge that I have read the disclosures on the back (or page 2) of this Authorization form, and understand that I have the right to revoke this Authorization (except to the extent that Petersburg Medical Center has already used or disclosed the information in reliance on this Authorization) by signing the Revocation of Authorization to Release Information form. This authorization expires \_\_\_\_\_ (insert applicable date or event). If I fail to specify an expiration date or event, this authorization will expire in 90 days from the date signed.**

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
If signed by Legal Representative, relationship to patient

\_\_\_\_\_  
Signature of Employee Releasing Record



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If Petersburg Medical Center is requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You may review Petersburg Medical Center's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Authorization.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice is posted in our office indicating the effective date of the Notice. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

***Additional Federal Substance Abuse Confidentiality Requirements***

***Item #4 - Under the Federal Substance Abuse Confidentiality Requirements, an authorization must include the purpose of the disclosure of substance abuse information even if the patient requests the disclosure.***

[If PMC seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual a copy of the signed authorization.]