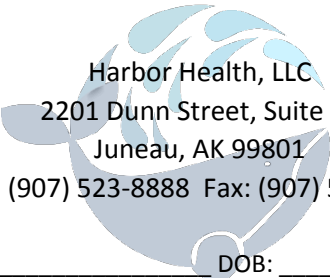


# Patient Authorization for Release of Medical Information

This form allows Harbor Health, LLC to send records on your behalf.



Harbor Health, LLC  
2201 Dunn Street, Suite #1  
Juneau, AK 99801  
PH: (907) 523-8888 Fax: (907) 523-8118

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Last 4 digits SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

I hereby authorize Harbor Health, LLC, its medical staff, employees, and/or representatives to release my protected health information in the manner marked below, and to the following:

Send By: (Choose ONE)  Fax  Mail  Secure Email

Send To:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Email: \_\_\_\_\_

Please Send:

All Records  or Specific Items

Only: \_\_\_\_\_

\*\*\*Depending on your request, it may take up to 2 weeks to fulfill your request.\*\*\*

This authorization will not expire except when revoked by the patient, legal guardian, power of attorney, or healthcare surrogate. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written request to Harbor Health, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected under federal privacy laws or regulations. I understand Harbor Health, LLC will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law. A copy of this authorization may be utilized with the same effectiveness as the original. I am entitled to receive a copy of this authorization.

\_\_\_\_\_  
Signature of Patient/Guardian/Power of Attorney/Health Care Surrogate

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

