ODYSSEY
FAMILY PRACTICE

11595 Kenai Spur Highway
Kenai, AK 99611
P. 907-313-4569
F. 907-313-4939

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

Patient's Full Name: _____ **Date of Birth:** ____/____/_____

Former Name(s): _____

I authorize Odyssey Family Practice to _____RELEASE records to or ____ OBTAIN records from:

Organization:_____ **Providers Name:**_____

Address: _____ **Phone:** _____

_____ **Fax:** _____

Information to be released:

___History & Physical
___Progress notes
___Consultation Reports
___Laboratory Reports
___Billing Records
___EKG Reports
___X-Ray Reports
___X-Ray Films
___Other (list)_____

For the purpose of:

___Further medical treatment
___Payment of claim
___Legal Request
___Personal
___Other (list)_____

Date(s) of Service: _____

_____

• The Protected Health Information (PHI) may include information about mental health, substance and/or alcohol abuse, HIV/AIDS, and STDs.

• This authorization may be used to share the same type of PHI indicated above which may be created in the future, until the expiration date.

• This authorization will remain in effect for one (1) year or until revoked in writing (written revocation should be mailed to Odyssey Family Practice P.O. Box 922 Kasilof, Ak 99610). I have the right to revoke this authorization at any time and understand that the revocation will not apply to action already taken as a result of this authorization.

• I may refuse to sign this authorization and doing so will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.

• I understand that PHI released per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.

_____ ____/____/_____ _____

Patient or representative signature **Date** **Witness**

COMPLETED FORM TO BE FILED ON PATIENT'S RECORD