

Medical record number _____

Providence Kodiak Island Medical Center
1915 E. Rezanof Drive Kodiak, Alaska 99615
Phone: 907.486.9597 Fax:907.486.9513

RELEASE OF MEDICAL INFORMATION

Please complete top part of form. When possible, allow 24 hours for processing.

Patient's Full Name: _____		Birthdate: ____/____/____	
Former Name(s): _____			
I authorize Providence Kodiak Island Medical Center to release the following information:			
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Surgical Reports	<input type="checkbox"/> Does your Doctor need x-ray films?	
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Emergency Reports	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Laboratory reports	<input type="checkbox"/> Consultation Reports	_____	
<input type="checkbox"/> X-ray reports	<input type="checkbox"/> Pathology Reports	_____	
From Date of Service: _____			
For the purpose of: <input type="checkbox"/> Further Treatment <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Personal			
Release to: <i>Complete name and address (include phone # if known)</i>			

I acknowledge that the information to be released may include material that is protected by Federal Law, such as Drug/Alcohol Treatment, Mental Health and/ or HIV and or AIDS, and I consent to its release.			
This authorization to release information is valid for 90 days from the date of signature, but may be revoked in writing at any time. (Revocation is not retroactive to any release made in good faith).			
X _____			
Patient signature (parent or guardian if patient is a Minor or has other court appointed representative)		Date	
Witness signature: _____			

RECEIPT: Records picked up by Patient Relative Other Mailed Faxed Courier

I hereby acknowledge receipt of medical record copies: _____
Signature

Record(s) released:	To be picked up: _____
<input checked="" type="checkbox"/> DS	Contact #: _____
<input type="checkbox"/> Op note	Charge for rec copies: 1-5 pg 10.00
<input checked="" type="checkbox"/> H&P	Ea. Add'l pg .30
<input type="checkbox"/> ER rept	Total pgs: _____ Total Chg _____
<input checked="" type="checkbox"/> Lab	Records released by: _____
<input type="checkbox"/> Consult	Date released: _____
<input checked="" type="checkbox"/> X-ray	
<input type="checkbox"/> Path Rept	
<input checked="" type="checkbox"/> Prog note	
<input type="checkbox"/> x-ray films	
DOS: _____	