



1915 E. Rezanof Drive
Kodiak, Alaska
99615

tel 907 486 3281

RECORD RELEASE CONSENT

I hereby authorize the Medical Records Department of Providence Kodiak Island Medical Center to release the necessary information contained in the record of _____, including psychological and psychiatric impairments to _____ concerning my illness and/or treatment during the period of _____ through _____ for the purpose of _____. **Any other use is forbidden.** This consent will expire in sixty (60) days after the date below, or sooner at my election.

IN ACCORDANCE WITH FEDERAL REGULATION (42 CFT Part 2):

I hereby also consent to the release of any and all alcohol and/or drug abuse treatment records under the same conditions as outlined above. I understand that such information cannot be released without my specific consent, except in special circumstances.

All authorizations must be signed by the patient or by an authorized person in the case of a minor or when a patient is physically or mentally incompetent.

Signature

Date

Relationship

Witness

TO RECEIVING AGENT:

Prohibition on redisclosure. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except within the specific written consent of the person to whom it pertains. A general authorization is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$500 in the case of a first offense and not more than \$5,000 in the case of each subsequent offense.

- | | | |
|--|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Other | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Consult | <input type="checkbox"/> Lab | <input type="checkbox"/> EKG |
| <input type="checkbox"/> ER Treatment Record | <input type="checkbox"/> Phys. Therapy Notes | <input type="checkbox"/> Face Sheet |

Information released by: _____ **Date:** _____