



Valdez Regional Health Authority, Inc.

911 Meals Avenue • P.O. Box 550 • Valdez, AK 99686
907-835-2249 • Fax 907-835-3735

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I AUTHORIZE VALDEZ REGIONAL HEALTH AUTHORITY, INC TO RELEASE TO:

(Doctor, hospital, attorney, insurance company, self, etc.)

Address (Street, City, State, ZIP) Phone Number Fax Number

THE FOLLOWING INFORMATION FROM THE HOSPITAL RECORDS ON:

Patient's Name Previous Names Birth date Social Security
Number

INFORMATION TO BE RELEASED:

- Inpatient, Admit/discharge, date _____
- Outpatient, date _____
- Emergency, date _____
- HIV/AIDS _____
- Drug screening _____
- Alcohol screening _____
- Other _____

I understand that treatment of drug or alcohol abuse, mental illness, or communicable disease, including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) will only be released when initialed above. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. This authorization expires 90 days from the date of signature, unless I specify otherwise or revoke it. I understand that I may be charged for copies of my medical records.

I HAVE READ AND UNDERSTAND THIS CONSENT AND I HAVE SIGNED IT VOLUNTARILY AND OF MY OWN FREE WILL.

Signature of Patient/Parent/Guardian

Date

Expiration Date: _____

Prohibition of Re-disclosure: This information had been disclosed to you from records that are confidential. You are prohibited from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

Med Rec No: _____