central peninsula hospital
250 Hospital Place, Soldotna, AK 99669
(907) 714-4404 * www.cpgh.org

MR# _____

Imaging Dept (907) 714-4581
Imaging Dept FAX (907) 714-4995

AUTHORIZATION TO RELEASE OF CONFIDENTIAL INFORMATION (to)

Patient's Full Name: **Date of Birth:**

Former Name(s)

I authorize **Name** _____ **Phone#** _____

Address _____ **Fax#** _____

To release to CENTRAL PENINSULA HOSPITAL IMAGING DEPARTMENT:

The following information (mark what is to be released):

- ❒ History & Physical
- ❒ Consultation Reports
- ❒ X-Ray Reports
- ❒ X-Ray Films
- ❒ Other (list) _____

For the purpose of:

- ❒ Further medical treatment

Date(s) of Service:

I acknowledge that the information to be released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization, and that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. In absence of a revocation, this specific authorization expires on _____ (if left blank, will expire 90 days from date of my signature). Maximum for authorization is 1 year from date of signature.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that the released information may not be further protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to obtain healthcare treatment. Mark one: **Patient Copy: _____ Given _____ Declined**

_____ _____ _____

Patient or representative signature **Date** Witness

Please fax reports immediately to (907) 714-4995.

Please send DICOM format CD to:
Central Peninsula Hospital
ATTN: Imaging Department
250 Hospital Place,
Soldotna, AK 99669

CPH Imaging also sends and receives electronically via DR Systems eMix.

Our eMix address is: **eMix@cpgh.org**

If you have any questions please call (907)714-4581

UNDER FEDERAL REGULATION CFR45 (HIPAA) RELEASE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IS NOT REQUIRED.

ATTEMPTS HAVE BEEN MADE TO OBTAIN AUTHORIZING SIGNATURE FROM THE PATIENT OR THEIR LEGAL REPRESENTATIVE. THIS INFORMATION IS REQUIRED FOR THE PATIENT'S IMMEDIATE MEDICAL CARE.

_____ _____

Signature of Healthcare Provider Date

COMPLETED FORM TO BE FILED ON PATIENT'S RECORD