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

MR # _____ **V #** _____

HIM Dept (907) 714-4564 Imaging Dept (907) 714-4580

HIM Dept FAX (907) 714-4683 Imaging Dept FAX (907) 714-4695

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION (from)

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

Former Name(s) SS#

I authorize CENTRAL PENINSULA HOSPITAL, INC. to release to:

Name **Phone#**

Address **Fax#**

Information to be released:

- ❒ History & Physical
- ❒ Discharge Summary
- ❒ Surgical Reports
- ❒ Other (list)
- ❒ Emergency Reports
- ❒ Consultation Reports
- ❒ Laboratory Reports
- ❒ EKG Reports
- ❒ X-Ray Reports
- ❒ X-Ray Films (refer to Img Dpt)

For the purpose of:

- ❒ Further medical treatment
- ❒ Payment of claim
- ❒ Legal Request
- ❒ Personal
- ❒ Other (list)

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.

Patient or representative signature **Date** Witness

FOR CPGH USE ONLY

PAGES _____ # FILMS _____ FEE $ _____ PROCESSED BY _____ DATE _____

RECORDS WERE ❒ MAILED ❒ PICKED-UP ❒ COURIER ❒ FAXED to # _____

RECORDS TO BE PICKED UP ON _____ CONTACT PHONE # _____

Receipt for Hospital Record Copies ❒ **ID Checked**

I hereby acknowledge receipt of the above noted medical records

Signature Date

Patient Copy _____ Given _____ Declined

RETRIEVAL AND COPY FEES

1-5 pp	$10.00
ea addtnl	$ .50
Xray Films	$10.50/sheet
Photos	$ 2.50/pg
STAT Fee	$20.00
Cert of Auth	$20.00

COMPLETED FORM TO BE FILED ON PATIENT'S RECORD