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

HIM Dept (907) 714-4564 HIM Dept FAX (907) 262-2753
HIM Email: medicalrecords@cpgh.org
Imaging Dept (907) 714-4580 Imaging Dept FAX (907) 714-4995

REQUEST FROM A THIRD PARTY – AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. **Patient's Full Name:** **Date of Birth:**
   Former Name(s)
   Phone number: Medical record number:
2. **Purpose or need for disclosure:**
   ☐ Ongoing Care ☐ Legal ☐ Insurance ☐ Personal Use ☐ Other (specify)_____
3. **Records to be released to:**
   ☐ Central Peninsula Hospital (See HIM or Imaging FAX numbers above) **ATTN:**_____
   ☐ Other (list): _____
   For date(s) of service: _____
4. **Records to be released from:**

☐ Central Peninsula Hospital	☐ CP Oncology	☐ CP Urgent care
☐ CP Bone & Joint Clinic	☐ CP Urology	☐ CP Surgery Center (Kenai)
☐ CP Family Practice (Kenai)	☐ CP Women's Clinic	☐ CP Spine
☐ CP Surgical Assoc. Clinic	☐ CP Neurology Clinic	☐ Serenity House Treatment Center
☐ CP Internal Medicine Clinic	☐ CP Foot & Ankle Clinic	☐ Heritage Place
☐ CP Family Practice & Peds Clinic (Soldotna)		

5. **Records to be released:**
   ☐ Physician Reports ☐ Complete copy (provide date range below) ☐ Billing Records
   ☐ Lab/Pathology Reports ☐ X-ray Reports ☐ X-ray Images
   ☐ Other (list): _____
   For date(s) of service: _____

I understand this disclosure is limited to the contents of the CPH Designated Record Set.

I acknowledge that the information being released may be related to sexually transmitted diseases, AIDS, or HIV. My health record may also include information about behavioral or mental health services, and/or treatment for alcohol or drug use.

I understand that this authorization does not include permission to release outpatient Psychotherapy Notes. Release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separate from the rest of the patient's medical record.

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 revocation, this specific authorization expires on _____, or 90 days from date of my signature, whichever comes first.

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 of disclosure of the information identified is voluntary. Refusal to sign this form will not affect my treatment, payment, or eligibility for benefits.

_____ _____ _____
Signature of Patient or Personal Representative **Date** Witness Signature