Kristen Lee, MD
David Abel, DO • Rebecca Schultz, PA-C
245 N. Binkley St., Ste. 103, Soldotna, AK 99669
(907) 260-4468 • fax (907) 260-4467
www.upstreamfamily.org

Release of Patient Health Information

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

Maiden/Other Names: _____

I hereby authorize Upstream Family Medicine to (*please initial*): _____ Obtain records from: _____ Release records to:

Name: _____ Phone: _____

Address: _____ Fax: _____

Information to be released:

- ☐ All Records (including those listed below)
- ☐ Demographic Information
- ☐ Progress Notes
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Psychiatric/Mental Health
- ☐ Other (list) _____

For the purpose of:

- ☐ Further Medical Treatment
- ☐ Payment of Claim
- ☐ Legal Request
- ☐ Personal
- ☐ Other (list) _____

Dates of service: _____

to _____

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 Upstream Family Medicine. 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 one (1) year from date of my signature.) Maximum for authorization is one (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 Legal Representative Signature **Date** **Witness**

Minors - A minor patient's signature is required in order to release the following information: 1) conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, and, 2) mental health conditions, and 3) drug and alcohol abuse diagnosis or treatment (this information is subject to Federal Regulation 42 CFR Part 2). I specifically authorize Upstream Family Medicine to release health information checked below:

- ☐ Reproductive Care
- ☐ Sexually Transmitted Diseases (including HIV/AIDS)
- ☐ Mental Health/Illness
- ☐ Drug/Alcohol Abuse

_____ _____ _____

Patient or Legal Representative Signature Printed Name Relationship to Patient

_____ _____ _____

Phone Date Signed Witness