Valley Medical Care
1801 Salmon Creek Lane • Juneau, Alaska

Phone: 907-586-2434
Fax: 907-586-2446
medicalrecords@valleymedicalcare.com

Authorization for Release of Medical Information

Patient Name _____ Date of Birth _____

Phone Number_____ Relation to Patient _____

Information to be released **FROM**:	Information to be released **TO**:
Valley Medical Care ☐ Other ☐	Valley Medical Care ☐ Other ☐
Facility Name & Address: _____	Facility Name & Address: _____
_____	_____
_____	_____
Fax: _____ Phone:_____	Fax: _____ Phone:_____
From: _____ To:_____ (MM/DD/YYYY)	Email _____

Purpose of Request: _____

_____

Type of Information: X-Ray Results ☐ Lab Results ☐ Office Notes ☐ Complete Chart*☐

If you ask for your complete chart to be sent, the office will default to releasing the last two years of records **unless date range in FROM box indicates a different span of time**

Patient Acknowledgment:

I understand information in my record *may* include sexually transmitted diseases acquired immunodeficiency syndrome (AIDS) or related diseases, or may include information about behavioral or mental health services or treatment for alcohol and/or drug abuse. *Please initial here if you do not want this information release.* **INITIAL _____**

I understand that any disclosure of information carries with it the potential for disclosure by the recipient and that the information then may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information released prior to this revocation. I understand authorizing disclosure of this health information is voluntary. I understand I am, not required to sign this authorization to receive treatment. I understand that if this information is require for participation in a research study, my enrollment may be denied if I do not sign the authorization.

I understand that I may inspect or request a personal copy of the information to be disclosed.

Please allow 5-7 business days for processing

Responsible Signature _____ Date _____

Please note: Authorization valid for **90 days only** and may be revoked in writing at any time prior to 90 days by notifying the Medical Records Department. **We cannot complete your request without complete information.**