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Phone: 907-203-0044 Fax: 907-331-0505
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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: ___________________________________DOB: ______________

Release From: ____

Information to be released:

_____ Clinical Summary Circle **ALL** or **Specify** From __________ to ________

_____ Problem List Circle **ALL** or **Specify** From __________ to ________

_____ Laboratory Test Results Circle **ALL** or **Specify** From __________ to ________

_____ Pathology Test Results Circle **ALL** or **Specify** From __________ to ________

_____ Imaging Reports Circle **ALL** or **Specify** From __________ to ________

_____ Complete Medical Record Circle **ALL** or **Specify** From __________ to ________

_____ Medications List Circle **ALL** or **Specify** From __________ to ________

_____ Other ____

Purpose of Request:

____Transfer of Care ____Consultation ____Continuity of Care ___Verbal Exchange Between Providers

Release to: **Karis Integrative Medicine**
851 Westpoint Drive Ste 301, Wasilla, AK 99654-7183
Phone: (907) 203-0044 Fax: (907) 331-0505
****Please fax records****

Terms: I understand that authorizing the disclosure of the above information is voluntary. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information. Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to the Health Information Services Department. **Unless otherwise stated, this authorization will expire one year from the date on which it was signed.** I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and is no longer protected by federal privacy laws or regulations.

Signature: ____ Date: ________________

Relationship to patient: ____