ILIULIUK FAMILY AND HEALTH SERVICES, INC.
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____
Social Security Number: _____ Previous Name: _____
Phone number: _____ Email: _____

☐ PERMISSION *IS HEREBY GRANTED FOR THE RELEASE OF INFORMATION:*

From: **Iliuliuk Family and Health Services, Inc.**
PO Box 144, Unalaska, AK 99685
Telephone: 907-581-1202
Fax: 907-581-2331/ 2332

To: _____
_____
_____
_____

For the use of:
☐ Continued Treatment
☐ Transfer of Care
☐ Personal (will be charged $0.60 per page)
☐ Legal
☐ Other (specify): _____

Type of Record released:
☐ Copy of complete health records
☐ X-Ray
☐ Lab Reports
☐ Medication
☐ Other (specify):_____

For the **Dates of Service** from _____ through _____

☐ REQUEST OF MEDICAL RECORDS FROM:

Clinic/Provider's Name: _____
Address: _____
_____
Phone/ Fax: _____

IFHS Provider: _____
To: Iliuliuk Family and Health Services, Inc
PO Box 144, Unalaska, AK 99685
Telephone: 907-581-1202
Fax: 907-581-2331/ 907-581-2332

Reason for Request:
☐ Continued Treatment
☐ Transfer of Care
☐ Other (specify): _____

Information Requested:
☐ Copy of complete health records
☐ X-Ray
☐ Lab Reports
☐ History and Physical
☐ Medication
☐ Other (specify):_____

For the **Dates of Service** from _____ through _____

I understand that records maintained on my behalf may contain information regarding the diagnosis or treatment of HIV/AIDS, other sexually transmitted disease, drugs and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. _____ (initial)

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that I do not have to sign this authorization in order to obtain medical/dental healthcare benefits, (treatment, payment, or enrollment). I understand that once the health information I have authorized to be disclosed reaches the noted recipient, the released information could potentially be re-disclosed and may no longer be protected by Privacy Laws. Therefore, I release Iliuliuk Family & Health Services from all liability arising from this disclosure of my health information.

x	PROCESSED
	Faxed
	emailed
	Mailed
	Self collect

_____ _____
Signature of Patient or Guardian Date Signed

_____ _____
Signature of Representative / ID number Relationship to Patient / Date Signed

*** This authorization expires one year from Date Signed.*
*** This authorization may be revoked at any time providing the information have not yet been released*
*** **IFHS STAFF** will ask for a copy of Representative's ID for filing, **if records are collected by next of kin***

Updated Sept 2022