



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

Patient's Name: _____ Date of Birth: _____
Social Security Number: xxx-xx-_____ 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/ 907-581-2332

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: _____

TO: IFHS Provider _____
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.

Table with 2 columns: X, PROCESSED. Rows: Faxed, emailed, Mailed, Self collect.

Signature of Patient or Guardian _____ Date Signed _____

Signature of Representative / ID number _____ Name & 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. Patient must sign consent for release.