780 S Snodgrass Dr. Palmer, AK 99645
Phone 907-357-7781 Fax 907-745-6573

RELEASE OF HEALTH INFORMATION

Please only sign top and bottom. This form is used when records are requested by IW&TCB, or a referring provider. Patient records are never released without permission.

I, (patient name and date of birth) ____, hereby authorize (custodian of records) ____, to release my individually identifiable protected health information in the manner described below. I understand that my information may be re-disclosed by the person or entity receiving my information from Integrated Wellness & Center For Birth, LLC, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my information from Integrated Wellness & Center For Birth, LLC. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.
This authorization expires on the following date or event: ____________________________________

Please send records to:

____

Please indicate what information you would like released:

☐ I would like this release to include all of my health information.

☐ I would like this release to include only health information that is necessary for a family member or friend to assist me with my care.

☐ Please limit use and disclosure of my health information to the following information:
____
____

I understand that I may revoke this authorization in writing at any time and that I have a right to receive a copy of this authorization, *this authorization was revoked on: ___________ (see attached revocation).*

______________________________ ________________
Signature of Client or Representative Date

____
Printed Name