110 S. Willow Ste 108
Kenai, Alaska 99611

KENAI VISION CENTER

Phone (907) 802-6468
Fax (855)825-6156

HIPPA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Medical records cannot be released until this form is completed and signed by the patient (if at least 18 years old) or parent or legal guardian (if under 18 years old). **You must complete this form thoroughly**. Please be aware that processing records can take up to 30 days, per HIPPA guidelines, but we make every effort to get them out as soon as possible. The fastest way to receive records is through our patient portal.

PLEASE PRINT

Step 1: Patient Name:_____ Date of Birth:_____

Email:_____

Step 2: I hereby authorize Kenai Vision Center to:

❑ **Release** my health information **To** ❑ **Obtain** my health information **From**

❑ **Upload my health information to my patient portal**

Name or Physician/Medical Facility**:**_____

Address:_____

Street City State Zip Code

Phone#_____Fax#_____

Step 3:

Description of Information to be released:

_____

_____

Requested Period: From: _____/_____/_____ To: _____/_____/_____

Month / Day / Year Month / Day / Year

This authorization, as may be applicable, extends to any medical records covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes

Step 4: **Purpose for disclosure is at the request of the individual based on the following:**

(This section must be completed before the records will be released)

❑Continuity of Care ❑Transfer of Care ❑Other Reason:_____

Step 5: **CONDITIONS OF AUTHORIZATION**

I have the right to revoke this authorization at any time by writing to the health care provider listed on this form

I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this form is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations. This authorization is valid for **90 days** for the release of information as indicated by date of signature below.

_____

Patient or Guardian Signature & Date