Bethel Family Clinic
Box 1908
Bethel, AK 99559
907-543-3773 F-907-543-3545

Your Non-Profit Community Health Center

Medical Authorization for Release of Information

Please allow 3 to 7 business days for requests to be processed.

Patient Full Name: _____ **Patient Date of Birth:** _____
(First, MI, Last) *(MM/DD/YEAR)*

Send Bethel Family Clinic medical information:

☐ I authorize the medical group/provider indicated below to send my medical records/information to Bethel Family Clinic:

Medical Group/Provider Name: _____

Address: _____

City: _____ **State:** _____ **Postal Code:** _____

Phone: _____ **Fax:** _____

Have Bethel Family Clinic send medical information to another Medical Group/Provider:

☐ I authorize Bethel Family Clinic to send my medical records/information to the medical group/provider indicated below:

Medical Group/Provider Name: _____

Address: _____

City: _____ **State:** _____ **Postal Code:** _____

Phone: _____ **Fax:** _____ **Secure E-Mail**_____

Release the following records: *Check*

___ **Complete Medical Record**
___ **Laboratory Results**
___ **Medication Lists**
___ **History and Physical Exam**
___ **Immunization Record**
___ **Clinic Notes**
___ **Other** (specify): _____

Method of Release: *Check*

___**Pick-Up**
___**United States Posta Service-Mail**
___**Fax** (ensure fax number is included)_____
___**Secure E-Mail**_____
___**Other** (specify_____

Service Dates from:_____ **to:**_____
Date information needed by:_____

Purpose of Authorization: _____

- I understand that signing this release of information is voluntary and will not be a condition of BFC treatment, services, or other benefits.
- I understand that this authorization will expire **six (6) months** from the date the form is signed.
- I understand I may revoke this release of information at any time by providing written notice to BFC and it will not affect my ability to receive BFC treatment and related services. However, it will not revoke any action already taken in accordance with this authorization.
- I have been informed to whom any information will be given, its purpose, and who will receive the information. I will receive a copy of this release of information after it is signed.
- I understand that the information sent or received as a result of this authorization may no longer be within our control, may be subject to disclosure, and as a result may no longer be protected by Federal Privacy Regulations.

Signature of Patient: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

Patient Full Name: _____ **Patient Date of Birth:** _____
(First, MI, Last) *(MM/DD/YEAR)*

Patient/Guardian Mailing Address: _____ *Phone:* _____