Ninilchik Traditional Council Community Clinic
P.O. Box 39368, Ninilchik, AK 99639
15765 Kingsley Rd.
(907)567-3970
(907)567-3902
www.ninilchiktribe-nsn.gov

Release of Medical Information & Medical Records

I hereby authorize the Ninilchik Traditional Council Community Clinic (NTCCC) and any of its employees, staff, or agents to use & disclose my confidential health information & medical records:

Patient Last Name:_____ First Name:_____ MI:_____

Date of Birth:_____ Social Security #:_____

Mailing Address:_____ Physical Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Treatment Date(s):_____ ☐ **Entire Medical Record**

Release Information to:_____
(Name of Individual, or Organization)

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax: _____

I am requesting the following information to be released:

- ☐ Entire Medical Record
- ☐ Lab Reports
- ☐ X-rays & Radiology Reports
- ☐ Other:_____
- ☐ Confidential Drug/Alcohol Abuse Information
- ☐ Confidential Mental Health Documentation
- ☐ Confidential AIDS/HIV Information

I am aware that there are separate fees for & consents for copies of my medical records. A request may take 30 working days to process. If your records are not received within 30 days, please call our Medical Records Department at (907)567-3970.

Patient Print Name:_____ Date:_____

Patient Signature:_____

I permit this confidential information to be released for the following purpose:

☐ Personal

☐ Continuation/ Transfer of Care

☐ Litigation for Review

☐ Insurance:_____
(Name of Insurance Company & Contact Information)

☐ Other:_____

This consent permits NTCCC to use and disclose my health information to carry out treatment, payment, or other healthcare related operations. Additional information regarding the uses and disclosures of confidential health information is described in NTCCC's notice of privacy practices. A patient has the right to review this notice prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operation purposes. NTCCC is not required to agree to a patient's request for restrictions.

I have the right to withdraw permission for the release of my information. If I sign this document and consent to the release of my confidential medical records, I can revoke that authorization at any time. This revocation must be made in writing and will not affect information that has already been used or disclosed. No further confidential information will be released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law.

Having read the above information, I hereby release, hold harmless, and agree not to sue the Ninilchik Traditional Council Community Clinic (NTCCC), its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

Patient Print Name:_____ Date:_____

Patient Signature:_____

Release of Medical Information & Medical Records Mail Request

I understand that Release of Medical Information & Medical Records requests that are mailed to this office must be notarized to protect the confidentiality of the patient's medical record, and to ensure proper verification of identity. This action also ensures that the information arrives at the intended destination.

The foregoing authorization and consent to release medical records was acknowledged and sworn to before me on this_____day of_____, in the year of 20_____.

State of:_____ County of:_____

As a duly appointed Notary Public, I hereby certify that the above listed person has personally appeared before me and I have witnessed the signature that is affixed hereon.

Notary Public Signature:_____

My Commission Expires:_____

Affix Seal here: