NTC COMMUNITY CLINICS

PO Box 39368 | Ninilchik, AK 99639
Ph. (907)567-3970 | Fx. (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 (Confidential records must be selected below)
- □ Lab Reports
- □ X-rays & Radiology Reports
- □ Other:_____

I would also like the following confidential information to be released: _____(initials)

- □ 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.

(Print) Patient Name:_____ Date:_____

Patient Signature:_____

Parent/Guardian Signature:_____

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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.

(Print) Patient Name:_____ Date:_____

Patient Signature:_____

Parent/Guardian Signature:_____

Include copy of ID if mailing/faxing/or emailing request to our office.

For Office Use Only
ID Verified □ Yes
Records were: □ Mailed □ Picked Up □ Faxed to #_____