Interior Community Health Center
Quality health care accessible to all

1606 23rd Ave.
Fairbanks, AK 99701
(907) 455-4567
Fax: (907) 458-1580
TTY/TDD: (907) 458-1587
www.myhealthclinic.org

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: **Date of Birth:**

Maiden Name/Other Names Known By: **Phone:**

Address: **City:** **State:**

PURPOSE OF DISCLOSURE (YOU MUST CHOOSE ONE OF THE FOLLOWING):

☒ **Mutual Exchange Between Interior Community Health Center And Fairbanks Community Food Bank (to include verbal)**

Address: **725 26th Ave**

City: **Fairbanks** State: **AK** Zip Code: **99701**

Phone **907-457-4273** Fax

PURPOSE OF DISCLOSURE (YOU MUST CHOOSE ONE OF THE FOLLOWING):

☐ Personal Use ☐ Legal ☐ Insurance ☐ Transferring Care to Other Physician/Clinic

☒ Coordination of Care ☐ Other (specify purpose):

I may refuse to sign this authorization form. I understand that ICHC will not condition or deny treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. ICHC's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, **it will expire 12 months from the date signed**.

I understand that if this information is disclosed to a third party, the information may no longer be protected by state or federal regulations and may be re-disclosed by the person/organization that receives the information.

I release ICHC, its employees and agents, and board of director members from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Patient Signature: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

Relationship to Patient or Description of Authority to Act for Patient: _____

Signature of Witness: _____ Date: _____

I hereby Revoke this Authorization_____ Date: _____