

Troy Medical Fairbanks

Authorization for Release of Medical Information

Remote Telehealth Services Alaska, LLC

Phone (907) 268-2737 · Fax (833) 941-2429

PATIENT

Patient name

Date of birth (MM/DD/YYYY)

Account # (if known)

I HEREBY AUTHORIZE TROY MEDICAL TO (PLEASE INITIAL)

Initials

Release records to / speak with

Initials

Obtain records from

Send records via

☐ Fax ☐ Mail ☐ USB

Person / agency

Address

City, state, ZIP

Phone / fax

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

☐ Entire medical record (chart notes only)

☐ Appointment note, dates:

☐ Imaging results, dates:

☐ Other, description, dates:

Please note that most of your records will be available to you through the online portal free of charge. **Large Volume Medical Records Fee:** If records requested is in excess of 100 pages or 5 years of records, you may be subject to a \$25.00 processing fee. **Digital Records Fee:** There is a \$5.00 fee to purchase a disc or USB flash drive for an electronic copy.

Please bring the signed form to the clinic. Do not email patient information.

Mountain View Medical Center, 2555 Phillips Field Road, ste 102, Fairbanks, AK 99709 · (907) 268-2737

Expiration, Revocation, Re-Disclosure, Acknowledgements

This authorization expires one (1) year from the date of signature. I understand I have the right to revoke this authorization before expiration by issuing a signed and dated letter of revocation to **Troy Medical**. Any information already released before the date of revocation is covered under this authorization. When releasing your medical information be aware that the information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that my medical records may include sensitive health information including but not limited to the diagnosis and treatment related to drug and/or alcohol abuse, AIDS/HIV status and or STD's. I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released. I understand that this authorization does not cover the release of psychotherapy notes, and that release of any such notes requires a separate, specified authorization that cannot be combined with any other authorization.

I understand that **Troy Medical** will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that I may request a copy of this signed authorization.

Signature of Patient, Guardian, or Legal Representative

Date

Relationship to patient

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